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New Principles of Ethics

What lay behind adoption of the 10 simple broad principles of medical ethics adopted by the House of Delegates of the American Medical Association in its general session in New York City, June, 1957?

Following the revision of the Constitution and By-Laws of the American Medical Association some 10 years ago, which revision was submitted to the House of Delegates by a special committee of which I happened to be a member, there began to appear resolutions on the floor of the House of Delegates requesting that the code of medical ethics under which the American Medical Association then operated also be revised. The special committee previously referred to was made a special committee of the House of Delegates whose function was fact finding and advisory to the House; this committee later was made a council.

In 1953 the House of Delegates mandated to the Council on Constitution and By-Laws the request to revise what was then called the "Code of Medical Ethics." The Council realized that it had a tremendous task, for the reason that when in revision you depart from that to which members of the medical profession are accustomed to refer, you need a good reason for such departure or you will get a rejection by the House of Delegates.

After many meetings and arduous and painstaking consideration the council realized that a great deal in the code was verbiage of medical etiquette or manners of one doctor

EDITOR'S NOTE: *The new Principles of Medical Ethics referred to by Dr. Pickett, who is chairman of the Council on Constitution and By-Laws of the AMA, is printed in the Organization Section of this Journal.*

to another, having nothing to do with medical ethics. In 1955 the council presented to the House of Delegates at the Boston interim session the "Proposed Principles of Medical Ethics and Precepts of Manners." In this booklet medical ethics was separated from etiquette or manners. The council also attempted, because of so much demand, to spell out that which the Principles of Medical Ethics and Precepts of Manners was supposed to cover.

This was presented to the House of Delegates by me as acting chairman of the council. The report was referred to the Reference Committee on Constitution and By-Laws, Dr. Frank Krusen, chairman.

After an all day session of the reference committee it was suggested by a member of the Board of Trustees that the proposed principles and precepts be laid on the table to be brought up at the annual session and that in the meantime the Judicial Council and Council on Constitution and By-Laws have a joint meeting and discuss objectionable features and needed corrections.

As mandated, the two councils met jointly in April, 1956, in Chicago. Also present were members of the law department of the American Medical Association. As we considered the booklet of proposed principles it was pointed out that in the council's eagerness to spell out as nearly as possible what the principles and precepts were supposed to cover, we had added much verbiage which created a danger of the American Medical Association running afoul of law. It was suggested that a brief statement of principles upon which the Judicial Council could place interpretations covering a given situation in a given state or territory would serve the American Medical Association better.

After lengthy discussion this thought was adopted and a joint committee of the two councils drafted the 10 proposed simple broad principles which were completely divested of medical etiquette. All members of the medical profession were given an opportunity to study the principles and give the Council on Constitution and By-Laws their reactions, favorable or unfavorable. The Judicial Council had no part after the setting up of the 10 broad principles; all hearings and revisions were made by the Council on Constitution and By-Laws. The final draft was submitted to and adopted by the House of Delegates of the American Medical Association in regular session in June, 1957.

What caused the objections to the 10 simple principles which prevented an earlier adoption by the House of Delegates?

There are two main reasons that may be offered and under each head many subobjections which will not be developed here. The first main reason was there was a feeling among the medical profession over America that if the brief simple principles were adopted, we would somehow lose the benefit of the valuable explanatory reports and opinions published by the Judicial Council during the past 50 years. This was overcome only by displaying the fact that the Judicial Council had ready for use a complete annotation of the principles covering prior interpretations of the Judicial Council. It was also shown to the House of Delegates that in the 10 simple broad principles the Council on Constitution and By-Laws had covered everything in the former code of medical ethics, leaving out only extra verbiage and that part pertaining to medical etiquette.

In the second place there was a feeling among many that the 10 broad principles were not specific enough in setting out do's and don't's, which is the prerogative of the Judicial Council. There was in the final session little objection offered before the Reference Committee on Constitution and By-Laws and none before the House of Delegates to the leaving out of the so-called medical etiquette or precept of manners, but in the main the profession preferred it.

As the preamble states, "These principles are intended to aid physicians individually and collectively in maintaining a high level of ethical conduct. They are not laws but standards by which a physician may determine the

propriety of his conduct in his relationship with patients, with colleagues, with members of allied professions, and with the public."

—B. E. PICKETT, SR., M. D., Carrizo Springs.

The Medical Profession and The American Cancer Society

It is a source of satisfaction to some of us who have been watching the development of the larger national health organizations with a wary eye to know that one at least, the Texas Division of the American Cancer Society, is or can be controlled by physicians. It was organized at our Texas Medical Association meeting in Galveston in 1946. Should it take the wrong track, medically speaking, we have only ourselves to blame.

In order that we can better understand the structure of the American Cancer Society as this structure affects us and our patients (and it does every day) we should recognize that the national board of directors of the American Cancer Society is composed approximately 50 per cent of laymen and 50 per cent of medical men with a physician as president. Its key committees, the ones most likely to affect us, are:

	Composition	
	M.D.	Other
Medical and Scientific Committee	34	
Research Advisory Council	8	8
Service Committee	15	3
Executive Committee	7	15
Total, All Standing Committees	150	42

In Texas, the medical man has an even greater influence and thus responsibility in the direction of the affairs of the Texas Division. The directors of the Texas Division are 50 per cent medical and 50 per cent lay with a physician as president. Its key committees and proportionate membership are:

	Composition	
	M.D.	Other
Executive Committee	16	15
Educational Committee	9	5
Service Committee	6	6
Budget and Finance Committee	5	5
Bylaws Committee	4	3

Thus, on the important working committees and on the Executive Committee itself, there is a medical preponderance of membership which certainly should give our profession the voice it needs in organizations such as this.

In addition, no county unit of the American Cancer Society is formed without the help of the president of the county medical society. If a cancer committee is not appointed to work with the local groups of interested laymen on the local board of directors, we must take some of the responsibility if medically unsound propaganda is released. On this particular subject, incidentally, every film and every piece of literature that is distributed is first cleared and accepted by the American Medical Association and appropriate specialty groups.

In Texas, the Texas Medical Association is asked for clearance on all lay materials through its Committee on Cancer. The film, "Breast Self-Examination," for example, is never shown to lay groups unless a member of the medical profession is present. The release of the film in Texas was delayed two years until each county medical society approved it for lay use.

It is indeed timely and advisable that attention be called to the policies of certain lay-sponsored health organizations that tend to infringe on the private practice of medicine. It is our obligation and duty as physicians to counsel with and advise the laymen who direct these organizations. Usually, these individuals are sincerely interested in the welfare of the people of their community and under proper enlightenment and guidance they will cooperate wholeheartedly with the medical profession.

Fortunately, the organization setup of the Cancer Society in Texas makes it possible for the medical profession to assume the major responsibility in determining all policies of the Texas Division of the American Cancer Society.

It is anticipated that the cooperation between the Texas Medical Association and the Texas Division of the American Cancer Society

will be even greater in the future than it has been in the past because both the laity and the interested members of the medical profession are insistent that complete medical clearance for all phases of the society's operation be effected.

—J. L. COCHRAN, M. D., San Antonio.

Control of Poisoning

In November, 1953, the nation's first poison control center was established in Chicago. Since that time, such centers have been springing up throughout the country in attempts to cut the mortality and morbidity of poisoning. Texas currently has a functioning center in Austin, and centers are being formed in Dallas, Fort Worth, and Houston. Moreover, financial costs have proved surprisingly small.

That the problem truly needs attention is evident from available statistics, most of which are based on deaths and admission into hospitals and therefore do not reflect the complete picture of the less serious but nonetheless potentially dangerous poisonings. Poisonings not resulting in death may leave permanent damage. In Texas in 1955, poisonings caused slightly more than 2 per cent of all accidental deaths (112 of 5,379 deaths). The peak incidence was in the age group less than 5 years old (38 deaths), but the age group 20-29 years had 20 deaths from accidental poisoning, 30-39 years 11 deaths, 40-49 years 18 deaths, and 50-59 years 12 deaths,* so that the problem certainly is not one just for the pediatrician.

Nevertheless, for Texans who are concerned especially with care of children, it should be noted that the annual death rate per 100,000 for accidental poisoning of children less than 5 years of age during the period 1949-1950 was not far from 4, whereas the rate for the entire United States was only 2.6—only 10 states and the District of Columbia exceeded the Texas rate. During that two-year period, drugs (especially the salicylates and barbiturates) caused 33 per cent of these deaths throughout the United States; petroleum products caused 25 per cent; and material for external use (including lead, corrosive substances, and arsenic) caused 36 per cent of the deaths.†

The increased employment of poisons in industry, agriculture, medicine, and warfare has been responsible for modern day toxicologic problems. The detergents, insecticides, and medicaments which, when used as intended, contribute immeasurably to our current high standard of living can become instruments of death when improperly used.

A physician confronted with a puzzling diagnostic situation always should consider the possibility of poisoning, even though there is no definite history of ingestion of or contact with a known poisonous substance. He should be familiar with the most common symptoms of the most common poisons and be prepared to assist in terminating exposure to the poison, administer antidotes, and apply general supportive measures as called for under the circumstances. Ready access to reference material on poisoning and occasional brushing up on the subject may prove lifesaving in an emergency. Doctors not served by a local poison control center in their own area might consider the advisability of sponsoring or cooperating in the establishment of such a unit where specially trained personnel, selected equipment and supplies, and files of information on specific products as well as on poisonings in general can be immediately available. In the absence of such help, any Texas doctor may call the Occupational Health Division of the State Department of Health in Austin (GR 6-2681; after office hours, GL 2-1334) for professional aid.

The obligation of the physician does not stop with diagnosis and treatment of poisonings. He needs to educate parents and children on the potential hazards of household preparations and suggest means of using and storing them so they will do no harm. Likewise, he needs to be-

Texas Mortality—1955; Summary of Accidental Deaths, Austin, Texas State Dept. of Health, Bureau of Vital Statistics.

†*Bain, K.: Death due to Accidental Poisoning in Young Children, J. Pediat. 44: 616-623 (June) 1954.*

come familiar with the agricultural and industrial hazards peculiar to his community and help to protect those likely to come in contact with them. (Information on economic poisons has been distributed in recent weeks by the Committee on Rural Health and Doctor Distribution of the Texas Medical Association.) He needs to give careful and specific directions when medicines are prescribed and to use judgment in the quantity ordered. Too, he needs to report promptly and completely to the local health department such cases of poisoning as come to his attention so that epidemiological data can be built up to guide future preventive programs. Recommendations worked out mutually by local medical societies and health departments can be of great value.

The encouraging aspect of poisonings is that so many of them would be preventable if adequate precautions were taken. It is up to all of us to take those precautions.

Committees Start Their Year

Committees which will serve the Texas Medical Association during the current year are listed in the Organization Section of this *Journal.* Among them are two entirely new committees, one which has been given independent status after functioning previously as a subcommittee, and three which have been changed from special to standing status.

The two new special committees, that on military and veterans affairs and that on nuclear and atomic medicine, were suggested by the outgoing President, Dr. Milford O. Rouse, with recognition of the increasingly important problems arising in these areas.

The committee that emerged from being a subcommittee of the Council on Medical Economics to become a special committee in its own right, the Committee to Study Contract Medicine, is expected to study various aspects of the corporate practice of medicine, including encroachment of the Veterans Administration and other governmental units into medical practice.

The Committees on Scientific Exhibits, School-Physician Relationships, and Rural Health and Doctor Distribution were given standing status so that they can have continuity of membership that leads to long-range planning and execution.

Another committee, which is not listed with the others but which has an important assignment, is that to study and suggest improvements in procedures of the House of Delegates. Such a committee, to work under the Speaker of the House, was recommended by two of the reference committees at the 1957 annual session.

Several councils and committees of the Association already have met to map their programs for the year. Most of them are looking forward to conferences in Austin at the time of the Executive Council meeting the week end of September 7-8.

It might be interesting, when one looks at the array of committees that carry on the work of the Texas Medical Association, to know that practices of effective state medical associations differ markedly in regard to committees. In Ohio, for example, only 16 committees carry on the work of the state medical society, whereas more than 70 are listed for Michigan. The chief attribute of committees in any successful organization must be that they act enthusiastically and with insight into the problems assigned to them.

Few if any state societies are more fortunate than the Texas Medical Association because with rare exception the committees are active, prompt, and well informed. The committees which are occasionally slow or function poorly often are handicapped by a chairman who is "too busy" or uninterested. It has been said that no committee is stronger than its chairman and no association is stronger than its committees. As long as our organization has capable, dedicated committeemen such as we now have, it will rank at the very top of the state medical organizations of America.

President's Page

AM I MY BROTHER'S KEEPER?

"Am I my brother's keeper?" has been repeated and answered many times. Certainly in our profession the answer is and should be, "Yes."

The thoughtful physician who speaks words of encouragement to the ambitious school boy or school girl planning to enter the profession of medicine, dentistry, nursing, or any other allied field is making a contribution to the healing arts. A few days ago one of our busier doctors in one of our larger cities spent almost an hour with two strangers. One of the strangers was a young lady just out of high school. The other was her mother. The young lady could not make up her mind about her future, but she thought she wanted to be a laboratory technician. The busy doctor made appointments with a laboratory school and two laboratories and helped escort her through them. The young lady was so much impressed that she has since recruited two other graduates to enter the same field.

The physician who spends many laborious hours teaching nurses, students, interns, and residents both the art and science of medicine is being his brother's keeper. If our nurses and young physicians entering their careers do not have the proper attitude toward their enormous duties, their teachers, councilors, and advisers must share the responsibilities for their shortcoming. The average young citizen in any field is anxious to do what is right and honorable. If properly directed and motivated, he will be just as eager to uphold the lofty ideals and principles of his profession as were his predecessors.

The physician in any community large or small who spends time and energy helping the new doctor in town get started toward a successful and ethical practice is contributing greatly to both his community and his profession. Nothing gives a young doctor more pride and confidence than a helping hand or a pat on the back from a would-be competitor who is better established in that particular community. The practice of medicine is a cooperative enterprise with one

great function. That function is to give to the people the very best medical care at the lowest possible cost. Only by helping those who follow us can such a policy continue to succeed.

The kindly ophthalmologist who spent 30 minutes on the telephone at midnight helping a stranger locate a doctor to relieve his thrombotic hemorrhoids was being his brother's keeper. The newcomer in town, knowing no doctors, consulted the phone book and called the first name he saw. He felt much more kindly toward his new home town and the medical profession after receiving the help of the ophthalmologist. It would have been less time consuming for the first doctor to say, "That is not my field of practice. Call someone else." But no one dedicated to his profession would have been able to sleep had he done such a thing.

The unselfish physician who leaves the banquet table; misses a golf game, a delightful hunt, or a fishing trip; or delays his much needed vacation to relieve suffering or to allay the fears and anxiety of the family concerned is certainly being his brother's keeper.

The thoughtful physician who senses undue financial strain on a family from multiple illnesses or consecutive unfortunate "breaks" never hesitates to reduce his fees, donate his time, or see to it that his patient is safely in a charitable institution which is built for such people. To do less would be failing in one's duty to see that the sick and injured receive proper medical care regardless of their ability to pay.

The medical profession as a whole and the family doctor in particular hold enviable positions in the hearts and minds of the average American citizen. This position was not gained by simply talking, nor did it come about by accident; but it was attained by many decades of active devotion to duty by many thousands of energetic, sympathetic men and women of medicine. We shall deserve or maintain this reputation only so long as we continue to be our brother's keeper.

Denton Kerr

ORIGINAL ARTICLES

Poisoning: A Four Year Survey

HAROLD L. DOBSON, M. D.;
C. W. DAESCHNER, M. D.;
RAYMOND MONDSHINE, M. D.;
NIC TENG, M. D.;
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Houston, Texas

EACH YEAR 8,500 persons die of poisoning in the United States. Of these, 1,450 die of accidental poisoning from toxic solids and liquids, while an equal number die of accidental poisonings with gases and vapors. There are 3,500 suicides involving solid and liquid poison and 1,900 utilizing gases. In addition there are 80 deaths from therapeutic misadventures with drugs, 43 deaths from venoms and insect bites, and 48 homocides using poisons. These

Dr. Harold L. Dobson and his co-authors are from the Departments of Medicine and Pediatrics, Baylor University College of Medicine and Jefferson Davis Hospital, and from the Houston-Harris County Poison Control Center. This paper was presented for the Section on Internal Medicine April 30, 1957, at the Texas Medical Association annual session in Dallas.

A survey of 323 poisonings treated at Jefferson Davis Hospital (1952-1955) shows that the largest group is accidental poisoning in the 1 to 3 year age group. Ingestion of hydrocarbons is most frequently encountered with lye, salicylates, and heavy metals being next. In adults, suicides, addiction and habituation, and barbiturate overdosage account for the bulk of poisonings.

averages are from the official mortality statistics for the five year period 1950 through 1954.[18] The rate of accidental poisoning in the United States is about four times that in Great Britain.[1] Texas is a leading contributor to the statistics of poisonings in this country, standing eleventh among the states with a death rate of 3.8 deaths per 100,000 population as compared with the national average of 2.6.[1] Since most of these deaths are preventable, there has been a concerted effort to reduce the number and mortality rate by a variety of agencies. One of the most effective devices has been the formation of poison control or information centers in urban areas.[14] An excellent review of this subject recently has been published in the *Journal of the American Medical Association.*[11]

As more chemical products are placed on the retail consumer market, the problem of poisoning becomes more complex. Many of these products contain several potentially toxic substances, and often the most dangerous component is not recognized as being toxic.[19] In addition, the insecticides and other chemical products which are receiving increasing usage in agriculture contain highly toxic materials. In Texas the problem is further complicated by the rapid growth of industries using and manufacturing a wide variety of chemicals. It is not possible to cover all facets of this complex problem; therefore, a review of the experience at Jefferson Davis Hospital, a city-

TABLE 1.—*Poisoning Cases Admitted to Jefferson Davis Hospital,* 1952-1955.

	Total Admissions	Deaths
Adults	62 (19.1%)	12 (19%)
Children	261 (80.9%)	2 (0.77%)
	323	14 (4.33%)

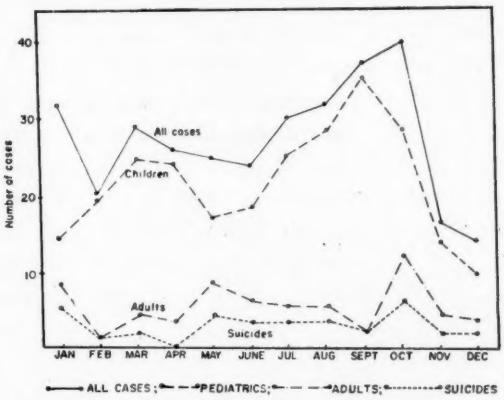

Fig. 1. The total monthly incidence of poisoning for the four year period, 1952-1955, at Jefferson Davis Hospital.

county institution, is presented since it is believed that experience there reflects the problem as it is encountered in any community. The period of 1952 through 1955 was selected because of the increasing interest in the problem of poisonings, especially by the Department of Pediatrics. The admissions for poisonings during this period are shown in table 1. It should be emphasized that for every patient admitted to the hospital at least 3 were treated on an outpatient basis, as only those with obvious symptoms or a definite history of poisoning were admitted. The great majority of patients were in the pediatric age group, which is consistent with the experience of others.[6, 10, 12, 18] The seasonal incidence is shown in figure 1.

PEDIATRIC POISONINGS

All the pediatric poisonings reported in this series were accidental, and the majority occurred in the toddler age group (12 to 36 months) with the peak at 2 years as shown in table 2. This has been the

TABLE 2.—*Age Range of Pedriatric Poisoning Patients.*

Age	No. Patients
0-6 mo.	2
7-12 mo.	30
13-18 mo.	84
19-24 mo.	85
25-30 mo.	19
31-36 mo.	18
4 yr.	17
5 yr.	4
6 yr.	4
8 yr.	1
12 yr.	2

experience reported elsewhere.[3, 12] The sex and race of the pediatric age group are shown in table 3. A majority of the patients were Negro. This is out of proportion to the ratio of Negro to white patients

TABLE 3.—*Sex and Race of Pediatric Poisoning Patients.*

	Negro	White	Latin American	Total
Female	95	17	13	125
Male	105	20	11	136
Total	200	37	24	261

seen in the pediatric clinic but is the usual finding according to the report of Bain.[1] The types of poisonings ingested by children are shown in table 4.

The petroleum hydrocarbons (kerosene, gasoline, red furniture polish, insect sprays, and lighter fluids, plus the pine oil distillate fractions) account for two-thirds of the pediatric poisonings and one-half of the entire series. The incidence in this series is higher than previously reported,[1, 3, 4, 12, 16] but is in agreement with the conclusion of Bain[1] that hydrocarbon poisoning is much more common in the South mainly because of the high incidence in Negro children. These substances are often readily available because of the common use of kerosene stoves and lamps in their homes.

TABLE 4.—*Poison Ingested by Pediatric Patients.*

Poison	Negro	White	Latin American	Total	Deaths
Hydrocarbon	141	21	16	178	2
Lye	12	0	0	12	0
Salicylate	4	4	3	11	0
Heavy metal	5	4	2	11	0
Iron	9	0	0	9	0
Phosphorus	4	2	0	6	0
Barbiturate	6	0	0	6	0
Phenol	2	1	1	4	0
Miscellaneous	18	4	2	24	0
Total	201	36	24	261	2

The principal symptoms seen in children who ingest a petroleum hydrocarbon product are coughing, choking, gagging, and often vomiting. Lethargy may appear in as short a time as 15 minutes after ingestion and usually clears in four to six hours, though in patients with severe pneumonic changes lethargy may persist for several days. The bulk of experimental evidence[8, 15] suggests that direct contamination of the tracheobronchial tree is the principal source of the pulmonary inflammation, which is the most important complication associated with hydrocarbon ingestion. This view is supported by clinical studies in which roentgenographic evidence of pulmonary inflammation has been demonstrated within 15 to 30 minutes after hydrocarbon ingestion. It is for this reason that gastric lavage is considered to be of little benefit to the patient and may predispose to further aspiration.

In any given case it may be impossible to be certain that a petroleum hydrocarbon has been ingested. In all suspected hydrocarbon ingestions the child should be hospitalized and observed for at least 24 hours. Thorough physical examination and roentgenographic study of the chest should be carried out at the time of admission and repeated at 6 and 24 hours. If no pathologic changes are evident at the end of this time, it is unlikely that there will be pulmonary complications. Two-thirds of the patients who subsequently show evidence of aspiration will have minimal changes in the chest roentgenogram within the first two hours, but the physician reading the film must be alert to the importance of such early changes as accentuation of bronchovascular markings, peripheral emphysema, and patchy infiltration.[5] These children should be started on therapeutic doses of a parenteral antibiotic agent as soon as they are seen. It is important that this be started early rather than

delaying until the chest roentgenogram becomes abnormal. A more detailed report of the hydrocarbon poisonings seen in this hospital has been published.[5]

Ingestion of salicylates in excessive quantities is second only to the hydrocarbons as a cause of poisoning in children in the United States.[1] The products involved here are aspirin, sodium salicylate, and methyl salicylate (oil of wintergreen). These produce a transient initial stimulation of the respiratory center with marked hyperpnea and respiratory alkalosis. In addition, there is interference with carbohydrate metabolism so that ketone body production and a metabolic acidosis usually ensue.[7] The early and continued marked hyperventilation leads to extensive pulmonary water losses and dehydration which complicate renal compensatory efforts. There is definite value in the use of early gastric lavage to remove as much salicylate as possible. Adequate fluid replacement is imperative depending principally upon glucose in water intravenously. As a rule alkalizing agents are unnecessary, and sodium chloride is given only as necessary to maintain electrolyte homeostasis.

Lye ingestion occurs far too frequently and is seen predominantly in the Negro population. In these patients the use of lavage is undesirable since there is little chance of removing any of the alkali, and there is an excellent chance of doing further damage to the eroded esophageal mucous surfaces with the lavage tube. Necessary symptomatic and supportive therapy is given during the acute phase.

After the burns have healed, the esophagus is studied radiographically by means of a thick barium swallow, and if areas of annular constriction are present, these are resected surgically. It is our belief that this approach is preferable to the use of bougie dilators, but this is an unsettled point. In our experience therapy with cortisone and related steroids is of no value and may lead to serious complications.

Ingestion of large amounts of iron, especially in the form of ferrous sulfate, leads to gastrointestinal bleeding, passage of gastrointestinal mucosa, shock, and possibly jaundice within 48 hours after ingestion. These symptoms occur because ferrous sulfate, in concentrated form, leads to damage of the gastrointestinal mucosa with edema, hemorrhage, ulceration, and occasionally necrosis.[2] Early lavage is definitely desirable whereas other supportive treatment in the form of vasopressors and blood transfusions are used as indicated.

Phosphorus poisoning usually occurs as a result of ingestion of roach paste. Marked abdominal pain, nausea, and vomiting are present early, and there is often a garlic-like odor to the breath. When the patient is seen soon after eating the phosphorus, gastric lavage is of value if the patient can tolerate the procedure. Control of pain and vomiting along with adequate fluid replacement should be accomplished as quickly as possible. Liver damage usually develops after 24 to 48 hours and may proceed to acute yellow atrophy. This is treated with glucose, adequate fluids, and vitamins as in other types of generalized liver damage. As a late sequela these patients may develop aseptic necrosis of the bone.

The heavy metal poisonings include mercury, arsenic, lead, thallium, cobalt, nickel, antimony, gold, and cadmium ingestion and inhalation. At the present time only mercury, arsenic, and thallium present a major problem. Thallium is an ingredient in several insecticides in 3 per cent concentration, which is quite toxic. This has been impregnated into cookie and cake crumbs in some of the preparations on the market in Texas. As a result there has been an epidemic of thallium poisoning with a mortality rate of about 10 per cent and another 10 per cent of the victims suffer from severe neurologic sequelae. The bulk of thallium poisonings in the Houston area have occurred since the period covered by this report. Symptoms may not appear for a period of days to weeks with epilation, severe neurologic lesions, dermatitis, and blindness being common clinical manifestations. If the patient is seen soon after ingestion, gastric lavage should be carried out as there is no known effective antidote for thallium.

Mercury and arsenic poisonings are best treated with BAL (British anti-lewisite or dimercaprol), which should be started at the earliest possible moment. The recommended initial dose is 2.5 mg. per kilogram of body weight repeated every four hours to a total dose of 15 mg. per kilogram in the first 24 hours. Smaller doses for a period of one to two weeks then may be given. Gastric lavage is of value early in removing the unabsorbed portion of the toxic substance. In our experience there has been more difficulty with BAL overdosage than there has been with heavy metal toxicity, primarily because the commercially available preparation of BAL is labeled in such a way that mistakes often were made in the measurement of the dose.

In addition to the previously enumerated poisonings, children often raid the medicine cabinet and become intoxicated with a great variety of drugs. Parents and physicians should remember that children in the 1 to 3 year age group will eat or drink anything they can put their hands on, whether it tastes good or not.

In studying poisonings as they occur in the pediatric age group, one is impressed with the fact that the majority of poisonings occur from substances commonly found around the home that are not regarded as being poisonous. It also should be noted that these materials usually are found (a) in the cabinet under the kitchen sink, (b) along the walls of the garage, and (c) in the medicine cabinet. One is also impressed with the low death rate in this

series; however, the morbidity rate is quite high in many of the patients and the degree of anxiety induced in the parent is extreme.

ADULT POISONINGS

The problems associated with adult poisoning are much different as may be seen in table 5. Accidental poisoning is rare, and the bulk of patients either are suicides or have problems associated with addiction and habituation.

The barbiturate toxicity group (table 5) includes those people who were admitted with barbiturate intoxication in whom suicide and/or habituation were suspected but could not be proved. It is our belief

TABLE 5.—*Classification of Adult Poisonings.*

	No.	Deaths
Suicide	34	9
Addiction and habituation	13	3
Barbiturate	7	0
Therapeutic and accidental	4	0
Industrial	1	0
Unknown	3	0
Total	62	12

that these three general groups—suicide, addiction and habituation, and barbiturate intoxication—are closely related, and all adult deaths in this series fell into one of these groups. Suicide by poisoning is found mainly in the white population and in our experience was only slightly more common in the female (table 6). Suicides may be divided into two groups: (a)

TABLE 6.—*Sex and Race of Adult Poisonings.*

	Male	Female	Total
White	21 (13)	23 (14)	44 (27)
Negro	4 (1)	9 (5)	13 (6)
Latin American	3	2	5
Total	28 (14)	34 (19)	62 (33)

Attempted suicides shown in parentheses.

those who are determined to die and often achieve their objective and (b) those who wants to commit suicide but do not want to die. In these latter persons the suicide attempts are often ineffectual but attention getting, and the patient would be very disappointed if he were to die. This is illustrated in table 7 in which it is seen that persons who have made repeated attempts at suicide have a much lower success rate than those who are determined to die.

The drugs involved in the three main groups of adult poisonings are shown in table 8. The barbiturates cause more trouble than any other agent, probably because they are easily available and are pleasant to take. The ideal treatment of barbiturate intoxication is unsettled. There is, however, no argument concerning the need for careful attention to fluid and electrolyte balance, use of oxygen, maintenance of a patent airway, and other symptomatic therapy.[9, 13]

TABLE 7.—*Adult Poisoning Suicides.*

	No.	Deaths
Known previous suicidal attempt	8	1
No previous attempt	26	8
Total	34	9

These 9 deaths are:
14.5% of all adult poisonings
75.0% of all adult deaths
64.3% of all deaths

Gastric lavage is of value in removing the excess material from the stomach if the patient is seen early. All too often, however, the lavage tube becomes clogged with the remains of the gelatin capsules. Whether or not to use stimulants and the type of stimulant selected remains a controversial point. It is generally agreed that the person who is not too deeply depressed may be allowed to sleep off intoxication as long as he is aroused at intervals and turned to prevent pneumonia. Some feel that this therapy

TABLE 8.—*Principal Poisons Involved in Suicides, Addiction, and Habituation in Adults.*

Poison	Male	Female	Total	Deaths
Barbiturates	5	15	20	1
Mercury	3	3	6	1
Arsenic	3	2	5	3
Phenol	0	5	5	0
Bromide	1	4	5	1
Narcotics	3	1	4	1
Phosphorus	1	2	3	1

is best for all but those patients who have respiratory depression, whereas others believe stimulants should be used if the patient cannot be aroused. A third group thinks stimulants should never be used and that respiratory depression should be treated by artificial respiration.[9, 13]

In general, stimulant therapy is not recommended, but if it is used, the selected drug should be given only in quantities sufficient to produce muscle twitching and the return of deep tendon reflexes. No attempt should be made to restore consciousness by stimulant therapy as this too often will lead to convulsions.

The general principles of BAL therapy for heavy metal poisoning outlined in the pediatrics section also apply for adults except that the initial dose is usually 3 or 3.5 mg. per kilogram of body weight and a total dose of 20 mg. per kilogram in the first 24 hours is not unusual.

In the patients with suicidal or accidental poisonings due to heavy metal ingestion, acute anuria usually occurs, and particular caution must be taken to prevent injudicious parenteral fluid therapy which may lead to water intoxication. Usually there is rather marked liver damage as well as renal and gastrointestinal damage, and later neurologic symptoms often appear. Convalescence in these patients is often prolonged.

The picture presented by the suicidal patient who has taken bichloride of mercury is much different from that of the patient who is poisoned with mercury through industrial exposure. In industrial poisoning personality and neurologic changes along with oral lesions in the form of loose teeth, excess salivation, and metallic taste are more characteristic.

In the four year surveys of poisoning at this hospital, only 1 patient with lead poisoning was found in spite of a house and attending staff on the lookout for such cases. It was felt that possibly not all of the cases had been discovered; therefore, inquiries were made of other hospitals in Houston, and they reported a similar low rate. Apparently lead poisoning is not the problem in this area that it is in other parts of the country.[1]

Poisoning with opium derivatives and synthetic narcotics is usually the result of suicide attempt or of buying illegal heroin which is too pure, leading to overdosage. The general outline of symptomatic therapy for barbiturate intoxication may be followed; however, in narcotic poisoning there is a specific antidote: N-allylnormorphine (Nalline). Given in doses of 5 to 10 mg. intravenously as indicated, with a top dose of 50 mg. in 12 hours, there is usually prompt relief of respiratory depression. Again it should be noted that this drug does nothing to restore consciousness, and any attempt to restore consciousness using Nalline usually will give poor results.

Bromide intoxication was surprisingly common in our series and should be suspected in any patient who has an unexplained mental disturbance. The chemical determination of the blood bromide level is well within the capabilities of the clinical laboratory, and a blood level of 75 mg. per 100 cc. or higher in a patient with a compatible clinical picture is diagnostic. Treatment is aimed at replacing the bromide by means of vigorous chloride therapy. It is also imperative that the source of bromide be eliminated (which in some instances may not be as easy as it sounds).

EMERGENCY MEASURES

When the family first calls a physician about potential poisoning, it is best to insist that the patient be brought immediately to the nearest well equipped emergency room. As a rule, caution should be used in advising the parents to induce vomiting as this is contraindicated in certain instances (ingestion of caustic agents and hydrocarbons). The use of the universal antidote (mixture of strong tea, charred toast, and milk of magnesia) by the family is satisfactory, but valuable time may be wasted in its preparation. The ingestion of raw egg white and milk may be equally effective. It is imperative that the physician insist that the family bring the container of the poison to the hospital. If the composition of the commercial product is not known, the manufacturing company, the Texas State Department of Health, or the nearest poison control center can be called on. If information concerning therapy for a particular poison is not available, usually there are physicians (often pediatricians) in the community who are interested in poisoning and can be of help. Information concerning proper therapy also may be available through a poison control center or a medical school pharmacology department.

SUMMARY

A review and analysis of the poisoning cases admitted to a city-county general hospital for the years 1952 through 1955 have been presented. Of the 323 admissions 81 per cent were in the pediatric age group. All of the pediatric poisonings were accidental and two-thirds were due to hydrocarbon ingestion. In the adult group suicides, poisonings associated with addiction and habituation, and barbiturate overdosage accounted for 87 per cent of the cases. Only 2 deaths occurred in the pediatric age group, whereas there were 12 deaths in the adult group. Various factors in the etiology and therapy of the more common poisonings have been presented.

The experience reported here is different from that in a private hospital, but the difference is probably more quantitative than qualitative.

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ABSTRACT OF DISCUSSION

DR. CARL NAU, Galveston: The authors are to be commended for calling to attention so forcefully the problem of poisoning—particularly in the pediatric group in which 90 to 100 per cent of all cases are preventable. They have pointed out the relative frequency of petroleum products (kerosene) as the offending agent (in 70 per cent of our cases at the University of Texas Medical Branch). It seems, however, that the question of treatment for children who have swallowed kerosene is still argued. Dr. Dobson and his team seem to consider gastric lavage a hazardous form of treatment and likely to be of little benefit to the patient. Drs. Olstad and Lord* of Rhode Island, in reviewing the benefits of lavage, report a series of cases in which 74.6 per cent were lavaged. Of these, 35.8 per cent developed pneumonia, whereas when no lavage was done 52.9 per cent developed pneumonia.

It is apparent that our greatest need lies in the area of education of the people in the following matters:

1. What substances are potentially poisonous.
2. How contact with poisons can be prevented (especially in children). Poisons are found in 50 per cent of kitchens, 25 per cent of bathrooms, and 25 to 50 per cent of garages.
3. The importance of and techniques for immediate first aid measures by parents and/or other lay people.
4. Improved hospital treatment resulting from a better knowledge of the toxic ingredients of substances known only by a trade name and by the availability in the emergency room (or elsewhere) of all necessary information for the effective treatment of "poisoned" people.
5. The need for improved labelling of all potentially poisonous materials.

We are especially concerned with (1) drugs and medicines (aspirin, sleeping pills), (2) cosmetics and toilet goods, (3) shampoos, (4) hair curling solutions, (5) hair straightening solutions, (6) hair dyes, (7) cleaning, polishing, and sanitizing agents, and (8) pesticides.

The American Academy of Pediatrics for a number of years has attempted to focus public and medical attention upon the large number of preventable deaths occurring each year from poisons. Several years ago the academy proposed the idea of poison control centers, strategically located, adequately financed, and competently staffed, which would serve as clearinghouses for poison information. Such centers could furnish information about the composition of substances known only by trade name, the expected symptoms and clinical course, and the recommended method for most effective treatment. The academy has been joined in its effort by numerous agencies such as the American Medical Association, American Public Health Association, and Industrial Medical Association, but the problem is essentially one for the local community. The United States Public Health Service plans to set up a national center; Houston is setting up a local center. It is strongly urged that the medical profession offer leadership and guidance but that all community resources and interests be utilized. Experience has shown that community participation yields the most effective results.

**Olstad, R. B., and Lord, R. M., Jr.: Kerosene Intoxication, A.M.A. Am. J. Dis. Child.* 83:446-453 (*April*) 1952.

Operating Room Hazards

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DEATH by anesthetic explosion is given heavy emphasis in media of public information, not only because it is the most dramatic of all surgical fatalities, but also because it is so unusual. Dramatic and newsworthy though death by anesthetic explosion may be, it is relatively rare and relatively infrequent among the causes of death of patients undergoing surgery.

Tragedies from fires and explosions have occurred in operating and delivery rooms ever since flammable anesthetic agents have been used. It is true that such accidents are rare and occur only once in approximately 80,000 to 100,000 anesthesias. However, definite hazards are present in places where flammable anesthetic agents are used. Therefore, definite precautions must be taken to avoid or, at least, to minimize further these catastrophes as there are more than 12,000,000 anesthesias administered in the United States annually.

The danger of fire and explosion is not limited to the field of medicine but is a factor in industry where flammable agents are used in the manufacture of many products. Industry has taken definite steps to minimize these hazards by improvements in the phys-

ical plant and by intensive instruction to personnel on safety measures. This practice has not been the general rule in most hospitals where flammable anesthetic agents are used. The hospitals alone cannot be accused of negligence along these lines. Until recently, recommendations made to hospitals for the prevention of fires and explosions have been so variable and controversial that the requirements have been difficult to fulfill. However, today, an agreement on the solution of many of these controversial problems has been reached.

Dr. George J. Thomas, associate professor of surgery and chairman, Section on Anesthesia, University of Pittsburgh School of Medicine, and director, Departments of Anesthesia, St. Francis General Hospital and Medical Center Hospitals, presented this paper for the Section on General Practice, April 29, 1957, at the Texas Medical Association annual session in Dallas.

Although anesthetic explosion is relatively rare, definite hazards are present wherever flammable anesthetic agents are used. The value of conductive floors, grounding, and wet towels is stressed for minimizing such hazards in anesthetizing locations. Also important are static electricity and humidity, as well as equipment and clothing. Thirty-five recommendations are given for safety in anesthetizing locations in hospitals.

FACTORS CONDUCIVE TO EXPLOSIONS

The three essential factors[1] required for the develment of an explosion are as follows:

1. *Combustible Gases or Vapors.*—In ordinary anesthesia practice, the gases or vapors are ethylene, cyclopropane, diethyl ether, and divinyl ether, or a combination of these. We must not exclude the nitrous oxide–oxygen–ether sequence, because this mixture is also flammable.

2. *Oxygen Supply.*—Oxygen is essential to all ordinary combustion. In anesthesia, oxygen is supplied pure, diluted in air, or in chemical combination with nitrogen in nitrous oxide.

3. *Ignition Source.*—Flammable mixtures require an ignition source for an explosion to occur. Ignition sources may be small flames, incandescent surfaces, local combustion initiated by catalysts, and electric sparks.

Factors 1 and 2 are essential to practical anesthesia. The third factor, the ignition source, is not essential and should be controlled or eliminated (table 1) if fires and explosions are to be avoided.

Open flames, such as those provided by alcohol lamps, Bunsen burners, matches, and smoking should be prohibited in rooms where anesthetics are either administered or present.

The use of incandescent or high frequency cauteries or coagulators within a distance of 2 feet from the mouth of a patient receiving flammable anesthetics should be prohibited unless a rubber sheet and wet drapes are properly applied.

On rare occasions, explosions of ether (from peroxides) have occurred due to the effect of sunlight. Ether should always be stored in original cans or dark glass bottles. Unless amber glass jars are supplied by the manufacturers, any ether remaining in the anesthesia machine should be removed and properly stored in the original container at the end of the day's work.

Electrical equipment should be inspected frequently to detect faulty operation, broken switches and plugs, frayed cords, and open sparks. Unless the equipment is explosion proof, it should not be used where concentration of flammable anesthetic gases may be present.

Roentgen-ray and fluoroscopic equipment can cause fire or explosion when flammable anesthetic agents are being used. Roentgen-ray apparatus is often brought into the operating room during the admin-

TABLE 1.—*Limits of Flammability of Anesthetics.*

Anesthetic Agents	Density of Air Taken as 1	Limits of Flammability: In Air		In Oxygen		In Nitrous Oxide	
		Lower	Upper	Lower	Upper	Lower	Upper
Ethylene	0.97	3.05	28.6	2.90	79.9	1.90	40.2
Propylene	1.45	2.00*	11.1	2.10	52.8	1.45	28.8
Cyclopropane	1.45	2.40	10.3	2.48	60.0	1.60	30.3
Ethyl chloride	2.23	4.00	14.8	4.05	67.2	2.10	32.8
Ether-divinyl	2.42	1.70*	27.0*	1.85	85.5	1.40	24.8
Ether-diethyl	2.56	1.85*	36.5*	2.10	82.0	1.50	24.2
Nitrous oxide	1.52	Not flammable		Not flammable		Not flammable	
Chloroform	4.12	Not flammable		Not flammable		Not flammable	

*Tests made in 8 liter, cylindrical, closed steel bomb.

After Jones, G. W.; Kennedy, R. E.; and Thomas, G. J.: Technical Paper 653, United States Bureau of Mines, 1943.

istration of an anesthetic agent. Modern shockproof equipment decreases the hazard of fire and explosion but does not eliminate it entirely.

STATIC ELECTRICITY

Static electricity, which is electricity at rest, is the cause of a high percentage of explosions in hospitals. It is usually produced on nonconductors but can be transferred and retained on insulated conductors.

Friction between dissimilar, nonconductive materials produces static charges. Some examples of this are the shuffling of feet across a rug on a dry day, running a comb through the hair, rubbing a glass rod with silk or synthetic fabric, and separation of woolen garments, upholstered furniture, and so forth. Static charges can also accumulate by inductive processes on articles that are near electrically charged objects.

Most materials permit electricity to pass through them, but some materials are such poor conductors that they are considered insulators. Metals and carbon are good conductors, whereas acids, salt solutions, plants, and animals are relatively poor conductors. Various oils, dry wood, silk, rubber, plastics, glass, and air are considered insulators.

Development of electrostatic charges in the average operating room is impossible to prevent. There is so much activity that frequently frictional contact occurs with one or another of the many nonconductive materials that are present in the room, and charges are thus generated.

The only means of preventing the accumulation of static charges thus produced is to provide paths by which the electrostatic charges may flow away as fast as they are generated. This can be done through the use of conductive floors and efficient conductive contact thereto. All movable conductive objects and personnel present in a room where flammable anesthetic agents are administered should have proper electrical contact with the floors.

CONDUCTIVE FLOORS

The floor is usually the most convenient common path for electrical charges to follow. Floors made of rubber, linoleum, tile, or marble are very poor electrical conductors. Neutralization of charges through such floors requires considerable time. A dangerous spark may occur before the neutralization is complete.

A terrazzo floor with conductive metal grilles may or may not be sufficiently conductive. Several other types of satisfactory conductive floors are on the market, and new ones are appearing from time to time. In planning the installation of conductive floors, consideration must be given not only to conductivity but to cost, durability, and appearance.

GROUNDING

Grounding chains are useful for removing static electricity from operating room equipment only if the following conditions are observed:

1. The floors must be definitely conductive or have metal dividing strips closely spaced.
2. The chains should make long-line contact with the floor if the floor is conductive, or with at least two metal strips if it is not. Chains so short that only one or a few links are in contact with the floor cannot be relied upon to remove static. Long chains on tables, stools, carriages, gas machines, and so forth will not be in the way if they are placed diagonally underneath the equipment. To insure greatest benefit, two diagonal chains could be used on each piece of equipment.
3. Chains should be cleaned occasionally to remove dirt, wax, grease, soap, oxide films, or other foreign substances which may accumulate between the links and cause high resistance. A stiff brush and a greaseless detergent should be used for this purpose.
4. Chains having open links are preferable to those of the ball or beaded type, which have conductive parts that are inaccessible for cleaning. They should be of material which will not rust or give off abrasive sparks when dragged over concrete or other hard surfaces.

If the floor has high resistance, the problem of grounding is solved satisfactorily by the use of one moistened and two wet towels or any other sizable pieces of fabric. The moistened towel is folded lengthwise; one end is placed under the patient's shoulder against the bare skin, and the other end is tucked between the mattress and the top of the op-

Fig. 1. A method of using wet towels for removal of static electricity during anesthesia.

erating table. One wet towel is laid above the caster from the base of the table to the floor toward the anesthetist's foot. The anesthetist's foot and the stool touch one or both of the towels. The other wet towel is stretched from the foot of the gas machine to the floor. Moistened and wet towels employed in such a manner provide excellent interconnection and grounding even though a standard test may indicate high electric resistance (fig. 1).

The explanation for this recommendation is as follows. Conduction of electricity to ground through a floor is accomplished through many paths of high resistance. When a contact to the floor is made with a chair, plate, or chain, only a few of the available paths to ground are used. When contact is made through a large wet towel, cloth, or pool of water placed on the floor, thousands of such paths are made available and the neutralization of charges is easily accomplished.[2]

HUMIDITY

Many anesthetists believe that an atmosphere of high humidity prevents the accumulation of static electricity and thereby eliminates explosions caused by electrostatic charges. However, several explosions have been reported with the relative humidity at 65 per cent. In April, 1949, an explosion attributed to a static spark occurred when the relative humidity was 76 per cent. While high humidity is not sufficiently reliable for complete control of electrostatic generation, a relative humidity of 55 per cent (plus or minus 5 per cent) will reduce the hazards of electrostatic discharges; this should be maintained the year round.

Air conditioned operating rooms are certainly desirable, but some authorities are of the opinion that artificially conditioned operating rooms are more dangerous than nonconditioned rooms, because of the removal of carbon dioxide from the air. These authorities believe that it is the carbon dioxide in the humid atmosphere which is effective in giving conductivity to insulators.

Whereas this seems plausible, it is not altogether true, because most chargeable surfaces and insulators in operating rooms are contaminated with dust, soap films, and so on, which probably furnish more ions in solution than would be furnished by the carbon dioxide. Unless the relative humidity is high, it may not prevent the possible electrification of rubber parts, woolen blankets, and synthetic fabrics. Furthermore, unless the equipment is in constant operation and in permanently good condition, it may fail to provide protection when it is most needed.

ELECTRICAL AND ANESTHETIC EQUIPMENT

Receptacles and plugs which cannot be pulled apart accidentally should be installed where needed. They should not be placed in or near the floor where heavy anesthetic gases are apt to pass over them, and they should be well out of the range of combustible gas mixtures. This precaution also applies to heaters, open motors, and switches.

In new building construction, the electric wiring should conform with the latest approved regulations of the National Fire Protection Association and the National Electrical Code.

Each gas machine should be equipped with conductive rubber breathing tubes, mask, and bag. Many of the conductive rubber breathing tubes today have connectors at each end made of plastic or some other nonconductive material. All connectors should be metal or of some other conductive material, or the purpose for which they were made is defeated.

High resistance rubber casters are still present on most gas machines today. Heavy bronze or brass window-sash grounding chains should be installed on all anesthetic equipment and operating tables, provided the floors are definitely conductive or have closely spaced metal dividing strips.

It is always dangerous to move anesthetic appliances, and extreme caution should be exercised, especially when they are moved across nonconductive floors. Altering the connection or changing connections during the course of anesthesia is hazardous and should be done only with extreme care. The safest procedure is to move the patient with the gas machine completely disconnected.

OPERATING ROOM EQUIPMENT

Mattresses, pads, and pillows should be covered with conductive rubber sheeting. All stretcher carriers should be equipped with the same, especially in buildings where nonconductive floors are still in use.

Operating tables, anesthesia stands, stools, and instrument tables should be equipped with a conductive material at the points where they make contact with the floor. Stools should be either left bare or covered with conductive materials.

Endoscopic instruments which operate on 6 or 8 volts and not more than 0.5 ampere do not constitute a hazard.

Wool blankets, plastic sheets, and most of the usual synthetic fabric materials should not be used in the operating room. Cotton blankets are satisfactory, but, if they are kept in warming compartments, some means should be provided to keep them from losing moisture.

CLOTHING

Cotton uniforms are desirable from an electrical standpoint since they retain a satisfactory conductivity at fairly low humidities and because they do not produce or acquire charge by frictional contact with other much used cotton articles, such as sheets, bandages, and sterilized bundles.

Conductive shoes should be worn by all hospital personnel. Personnel wearing ordinary rubber or synthetic soled shoes may be static carriers regardless of the type of floors in use. Soles of leather or other absorbent material can be brought to the desirable value of 1 megohm or less in a few minutes by standing on a wet pad soaked with 5 per cent calcium chloride solution.

RECOMMENDATIONS FOR ANESTHETIZING LOCATIONS IN HOSPITALS

The following recommendations have been made for safety in anesthetizing locations in hospitals:

1. "No Smoking" signs should be posted in all corridors in the operating, delivery, and emergency room suites, and areas where inhalation therapy is in use.

2. Controlled temperature and humidity the year round is desirable in *all* anesthetizing locations. The temperature should range from 72 to 78 F., and the relative humidity should be maintained at 50 to 60 per cent. A recording instrument should be placed in one or two strategic points in the surgical suite to show and record the hourly temperature and humidity.

3. Adequate ventilation in anesthetizing locations is also very helpful in minimizing fires and explosions with flammable anesthetic agents. It is recommended that 8 to 12 air changes per hour should be established in these locations.

4. A good conductive floor is essential; selection of a dependable floor should be made only after a reliable consultation has been held.

5. A grounding device should be installed on all movable equipment in the anesthetizing area.

6. Conductive casters on the equipment should be kept free of powder, lint, and other objects that have a tendency to raise the electric resistance of the wheels and defeat their purpose.

7. Anesthesia machine parts such as breathing tubes, bags, and masks, should be of good quality conductive rubber. It is advisable to replace rather than repair these parts because holes or cracks covered with adhesive tape or other means continue to permit leaks of anesthetic agents.

8. The anesthetist's stool should have a conductive seating surface such as stainless steel. Ordinary painted surfaces are usually insulating and should be eliminated. Caution is advised in the use of adhesive tape to prevent slippage, so that not more than 50 per cent of the contacting area is covered with the tape, which is insulating. Conductive pads, to be used only on unpainted stool tops, are suggested. These stools should be grounded to the floor by means of conductive leg tips or heavy brass or bronze sash chains, or by removal of nonconductive leg tips so that bare metal is in contact with the floor.

9. Since paint and enamel are insulators and difficult to ground, all equipment used in the anesthetizing locations should be of stainless steel, chrome plated, or aluminum material.

10. No one should be permitted in the anesthetizing locations unless wearing cotton uniforms.

11. Woolen blankets, plastic sheeting, and synthetic fabrics, generally should be excluded from anesthetizing areas. This includes silk, nylon, and sharkskin uniforms.

12. All persons entering the surgical suite should be required to measure the electric resistance of their footwear on the conductometer provided for this purpose at the entrance into the corridor.

13. All personnel and visitors in the anesthetizing locations should wear conductive footwear, or the equivalent, and cotton uniforms. Crepe soled shoes, wool, silk, nylon, sharkskin, or other similar synthetic fabrics should not be permitted in such areas. Note: nylon hosiery and undergarments may be permitted providing the outer garment is cotton and the footwear is conductive.

14. Mattresses on delivery, emergency, and surgical tables and carriages should be covered with conductive rubberized sheeting.

15. It is my opinion that illuminating instruments and cautery equipment operating on less than 0.5 ampere and less than 9 volts are safe to use in anesthetizing locations. However, it is believed by some authorities that any electric arcing, even with voltage as low as 8, either by a switch or defective connections anywhere in the circuit, may produce a spark of sufficient energy to ignite combustible anesthetic agents. Therefore, it is important that all electrical equipment, regardless of amperage or voltage, should be properly maintained; it should be connected and power turned on before approaching the patient.

16. All electrical cords and fixtures in the anesthetizing locations should comply with the National Electrical Code for Class I, Division 1, and Group C areas.

17. Flammable germicides should not be used for the preoperative preparation of the field.

18. Anesthesia equipment should not be draped; paper and other wrappings should be removed from gas cylinders and the label should be legible.

19. Wangensteen electrical drainage equipment can be used in anesthetizing areas. However, this electrical device should be kept *at least* 5 feet away from the anesthesia apparatus.

20. Since anesthetic vapors are heavier than air and have a tendency to flow toward the floor, an explosion-proof foot pedal switch should be used with the Bovie and other electrical units operated in such manner. These are available today and should replace the older nonexplosion-proof type.

21. Cyclopropane, ethylene, and the various ethers can be stored together but *should be kept separated* from oxygen and nitrous oxide.

22. Conversely, oxygen and nitrous oxide can be stored together but not with the just mentioned gases or liquids.

23. There should be three or four no. 5 carbon dioxide extinguishers located in strategic areas in the surgical and obstetrical suites. The carbon dioxide will smother an anesthetic fire whereas the soda-acid and water will spread it.

24. The following rules should be emphasized to the personnel:

a. Do not permit oil, grease, or flammable material to come in contact with oxygen cylinders, valves, regulators, fittings, or gages.

b. Do not lubricate regulators, fittings, or gages with oil or any other such combustible substances.

c. Oxygen cylinders or apparatus should not be handled by anyone having oily hands or using greasy gloves or rags.

d. High pressure valves on the cylinders of all gases on anesthetic machines should be opened before approaching the patient with the apparatus.

e. Oxygen cylinders should never be draped with any material such as hospital gowns, masks, or caps.

f. Always clear the particles of dust and dirt from the outlet of each cylinder by slightly opening and closing the valve before applying any fittings to the cylinder.

g. Do not permit oxygen to enter the regulator suddenly; open the cylinder valve *slowly*. When opening the valve, point the face of the regulator gage away from the operator and other personnel.

h. Do not use oxygen fittings, valves, regulators, or gages for any service except oxygen.

i. Gases should never be mixed in or added to any oxygen cylinder or any other cylinder by hospital personnel.

j. Do not attempt to use regulators that are in need of repair or cylinders having valves that do not operate properly.

k. Do not attempt to repair defective oxygen equipment unless you are properly trained and qualified for such work.

l. Cylinder valves should be fully opened when in use.

m. Cylinder valves should be kept closed at all times except when gas is actually being used.

25. A suitable electrical instrument should be purchased for the maintenance engineering department to check periodically the resistance of floors, and all movable equipment in the anesthetizing locations. Instruments for measuring electrical resistance of floors, personnel, and equipment in the anesthetizing locations may be obtained from numerous manufacturers.

26. Measurement of the floor resistance and the grounding devices, as well as electrical equipment in the anesthetizing locations, should be made and recorded every month by the maintenance electrical engineering department and presented to the hospital administrator for a review and countersigning the inspection. The inspection could be made during the week end and without additional cost to the hospital. It is a very essential item, and it can be helpful in the event of litigation.

27. A personnel or shoe testing meter should be installed in the corridor at the entrance to the anesthetizing location to measure the resistance of footwear.

28. Copies of Bulletin 56 of the National Fire Protection Association on "Safe Practice for Hospital Operating Rooms" may be obtained for 25 cents per copy from the Association, 60 Batterymarch Street, Boston 10.

29. When the ground contact signal (red light) lights, the administration of combustible anesthetic agents shall be discontinued at the earliest possible moment. Following completion of the operation, the operating room in which the signal functioned shall not be used until the reported electrical defect is remedied.

30. No equipment should be used in anesthetizing locations unless it has been inspected, studied, and sanctioned by the director of the Department of Anesthesiology, who is well versed on this subject.

31. Piped oxygen, air, and suction is economical and very useful in the anesthetizing areas.

32. Recovery rooms should have piped oxygen and suction for all patients in this area.

33. It shall be the responsibility of the anesthetists (or the person appointed by the hospital authority to act in that capacity) to enforce the previously mentioned regulations.

34. Employ block anesthesia or spinal analgesia or produce anesthesia with nonvolatile agents when these are suitable.

35. Use the carbon dioxide absorption technique in the administration of inhalation agents. The anesthetist should carefully observe the following routine: (a) Touch the patient and the gas machine before releasing vapors or gases. (b) Bring the mask into contact with the patient's face after the mask is connected with the apparatus. (c) Allow only a nonflammable mixture to flow through the machine until all contacts are made. A low oxygen concentration might be used for the first half minute of the induction period. (d) Use deliberation in all movements. Break and remake connections of the face mask with the patient and the anesthesia apparatus only when each part is in your own hands.

Finally, always be on the alert against that silent, unseen hazard which is least understood and most neglected—static or frictional electricity. A spark that scarcely can be seen or felt can prove disastrous.

SIMPLE AND RELIABLE TEST

Nonflammable anesthetics should be employed when an electrocoagulating or fulgurating apparatus is used in connection with eye, ear, nose, or throat surgery. However, in the event that a patient, already anesthetized with a flammable mixture, requires electrocauterization in the vicinity of the neck or face, the following procedures[3] are recommended:

Fig. 2. A method of drawing a sample of exhaled gas and air. [After Thomas, G. J.: Do You Know, American Society of Anesthesiologists NewsLetter 16:14-15 (Nov.) 1952.]

1. Discontinue administration of the anesthetic and move the equipment to a place at least 5 feet away from the patient.

Fig. 3. Plunger removed and mouth of syringe barrel applied to alcohol lamp flame. [After Thomas, G. J.: Do You Know, American Society of Anesthesiologists NewsLetter 16:14-15 (Nov.) 1952.]

2. Allow the patient to breathe room air for *not less than 3 minutes.*

3. Insert a 10 cc. syringe halfway into the oral cavity, and take a sample of the exhaled gas from the patient (fig. 2).

4. Without moving the plunger, carry the syringe containing the sample of exhaled gas to a nearby room where an alcohol lamp may be safely lighted.

5. After the lamp has been lighted by an assistant, remove the plunger of the syringe and bring the mouth of the barrel into contact with the flame (fig. 3). If any flammable gas is present in the barrel, it will be ignited and a puff of flame will be seen. Electrocauterization should not be attempted until a sample of the exhaled gas gives a negative test.

CONCLUSIONS

Manufacturers, architects, and builders concerned with hospital construction should be thoroughly familiar with the hazards common to anesthetizing areas and should supply materials and construction which conform with modern safety code requirements.

Hospital management should be grateful for the intense interest being shown at present in safety and should regard it as a duty of the surgeons, anesthesiologists, nurses, and other operating and delivery room personnel to be thoroughly instructed in all of the causes of anesthetic fires and explosions. This duty should be impressed upon each member constantly, and a method should be devised to insure complete adherence to all recommended precautions.

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CORRECTION: ANDERSON SECRETARY-DESIGNATE

Robert B. Anderson, guest speaker at the concluding General Meeting Luncheon at the Texas Medical Association annual session in Dallas, May 1, 1957, and author of "The Art of Introspection," his address published in the June issue of the *Journal* (pages 387-389), should have been identified at the time of publication as Secretary-Designate of the Treasury and formerly president of Ventures, Limited.

Fractures Which May Be Safely Handled In the Office Of the General Practitioner

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THE PHYSICIAN in general practice is often the first to be consulted by patients with acute injuries. It is highly important, therefore, that this physician be able to select the problems which he may safely and adequately manage through his office practice and with the patients remaining at home. At the same time it is just as important that he be cognizant of those fractures and more serious injuries

Dr. H. R. McCarroll, assistant professor of clinical orthopedic surgery, Washington University School of Medicine, presented this paper as a refresher course April 30, 1957, during the Texas Medical Association annual session in Dallas.

Since the general practitioner often is first to see the patient with acute injuries, it is important that he know which problems he may safely treat in his office or at the patient's home and which more serious injuries, such as compound fractures, need specialized care. In many fractures, conservative therapy gives excellent results. Simple rules for treatment are presented.

for which the patient should be hospitalized or should be referred to a surgeon adequately trained in this field. The scarcity of hospital beds in recent years has made it imperative that many problems in all phases of medicine and surgery be managed in the office and at home wherever possible. In many fractures a very conservative program of therapy will afford an excellent result. If these conservative measures fail, however, the physician in general practice

should advise or accept consultation in order that more radical therapeutic measures may be instituted if they are then deemed advisable. If the physician in general practice will follow these simple rules, he may safely and adequately treat many fractures and dislocations with complete assurance of justice to all.

THE CLAVICLE

The fracture of the clavicle represents a type of injury which seldom requires surgical intervention and which, in the majority of instances, may be safely managed by the general physician. In children and in the majority of adults the only treatment indicated is the use of a figure-of-8 type of bandage support which is placed about the two shoulders and anchored firmly in order to hold the shoulders in extension and moderate elevation. Such a figure-of-8 bandage may be easily constructed with a strip of stockinette placed over a strip of absorbent cotton, sheet cotton, or felt padding. After it is placed in position about the two shoulders, it is pulled snugly and anchored with two safety pins. It then may be reinforced with adhesive strips in order to avoid stretching with continued use of the shoulders and extremities. This figure-of-8 bandage may be reinforced with plaster of paris, but this is more rigid, more uncomfortable, and not essential. When reinforced with plaster of paris, the bandage becomes more irritating to the skin and carries some added risk of pressure on major vessels and nerves about the shoulder girdle. The figure-of-8 bandage should be changed at weekly intervals in order to avoid irritation of the skin in the axillae. If there is a tendency for the outer fragment of the clavicle to drop with the shoulder, this may be controlled by the addition of a sling which is tightened sufficiently to elevate the shoulder to the proper level.

In children a fracture of the clavicle heals in approximately four weeks, and it is usually safe to discontinue the support after this period of time. Roentgenograms, of course, should be made during the course of the treatment, and the figure-of-8 support should be continued until satisfactory bony union has occurred. In adults bony union does not take place as rapidly, and the figure-of-8 support may have to be continued for six or eight weeks.

The only instance in which surgical intervention is indicated in a fracture of the clavicle is the occasional case in which extreme displacement of the fragments in the adult patient makes it impossible for bony contact and bony union to occur, or in the case in which a pointed or comminuted fragment has penetrated beneath the skin to the extent that a secondary compound wound could easily occur.

THE SHOULDER AND HUMERUS

Certain fractures about the shoulder may be safely managed by the physician in general practice. Fractures of the tuberosity and fractures of the surgical or anatomic neck of the humerus with no displacement or very minimal displacement fall into this group. Fractures of this type frequently require no more support or immobilization than the addition of a sling to the extremity. If the pain is so severe that immobilization of this type is not sufficient, a Velpeau bandage may be used until the acute pain has subsided. The Velpeau bandage should be removed as soon as the pain has subsided sufficiently and a sling substituted. Exercises for the shoulder should be instituted early in a fracture of this type, and active use of this extremity should be encouraged as soon as roentgenograms show satisfactory union of the fracture. This may require four, six, or eight weeks depending on the type of fracture encountered. Those fractures about the head and neck of the humerus which are badly displaced usually should be referred to an orthopedist for manipulative reduction or open reduction as the individual case may indicate.

In older people with generalized bone atrophy, fractures of the head of the humerus are frequently encountered. These fractures are often severely comminuted and badly displaced, and manipulative reduction or open reduction offers little hope of improvement. The exact age group in which such fractures should be treated conservatively is difficult to state. They usually occur in persons past 60 years of age and, in the presence of severe comminution and displacement of fragments, conservative therapy is usually advisable. A fracture of this type, therefore, may be safely managed by the physician in general practice in his own office. The pain in such fractures is quite severe in the beginning, and the shoulder usually should be immobilized until the acute pain has subsided. A Velpeau bandage or the use of a sling and swathe about the arm and chest will protect the extremity and offer a great deal of comfort. This type of support should be continued for three or four weeks depending on the type of fracture and the amount of pain which is present. After that period a sling should be substituted and active exercises of the extremity should be encouraged. Pendulum exercises represent the best form of initial active movement, and the patient then should be encouraged to begin active use of the extremity for light work as rapidly as possible. In fractures of this type satisfactory results usually can be obtained although a considerable amount of disability and limitation of motion always follow. The patient will show excellent use of the extremity as long as the arm is kept at the side, but elevation of the extremity and its attempted use in an elevated position

remain markedly impaired. Often, however, active abduction of 90 degrees can be obtained even though the extremity may not be elevated above this level.

Traumatic dislocations of the shoulder also may be managed in the office of the general practitioner without the need for hospitalization. Many of these shoulders can be reduced without the aid of a general anesthetic. The patient can be given morphine or Demerol and placed in a prone position on the examining table with the involved shoulder lying flush with the margin of the table and with the arm of the involved extremity hanging at the side of the table in a dependent position. After the preliminary medication has had time to take effect, mild traction and manipulation of the shoulder with rotation of the arm often will reduce the dislocation. If this fails, the patient should be placed on the back and the Kocher maneuver carried out. The involved extremity is first placed in a position of abduction and external rotation, which can be obtained slowly without great pain. While the position of external rotation is maintained, the arm is then dropped to the side so that the humerus parallels the long axis of the body. The third step in the maneuver consists of simply internally rotating the extremity so that the forearm is swung across the trunk. In the majority of instances the dislocation is reduced before the second step of the procedure has been completed. Occasionally, however, the dislocation may be more difficult to reduce and a general anesthetic for complete muscle relaxation may be required. In those instances where reduction of the dislocation is difficult, the Kocher maneuver should be repeated with the closed fist of an assistant held deep in the axilla of the patient as the maneuver is carried out. This often will make it possible to swing the head of the humerus into the glenoid fossa without great difficulty.

Immobilization of the dislocated shoulder should be continued for a period of at least three weeks, and this is particularly true if the patient has suffered the first dislocation. Immobilization over this period of time in which the soft tissue injuries are permitted to heal affords the best protection against possible future recurrent dislocations. (An exception to this may exist in patients 65 years of age and over in whom the use of a sling and early active exercise of the shoulder may be advisable.) This immobilization can be obtained best by means of the ordinary Velpeau bandage, which immobilizes the involved extremity to the thoracic cage. This Velpeau bandage should extend across the opposite shoulder as well as the involved shoulder in order to prevent its slipping out of position. If the dislocation of the shoulder continues to recur, surgical reconstruction should be considered, and for this the services of the orthopedic surgeon should be obtained.

Spiral fractures of the shaft of the humerus and certain transverse or mildly comminuted fractures of the shaft of the humerus also may be treated by conservative measures in office practice. If there is no marked displacement of the fragments and no evidence of associated radial nerve injury, the simple application of a hanging cast usually will afford a satisfactory result. The hanging cast is applied as a long arm plaster cast with the elbow flexed to 90 degrees. The cast is suspended from the neck by means of a loop about the wrist. This permits the arm to hang at the side in a perpendicular fashion, and the weight of the cast serves as traction on the fracture. The portion of the cast which incorporates the upper arm should be extended as high as possible into the axilla in order to add additional support to the fracture and maintain satisfactory alignment. This cast should be worn until roentgenograms reveal a satisfactory amount of surrounding bone formation, and not until then should an attempt be made to remove it and substitute a sling. If movement of the arm in the hanging cast produces considerable pain and the patient remains apprehensive, a swathe about the arm and chest will add additional support to the fracture. When this is used, a thin cotton pad should be placed between the upper portion of the cast and the thorax. A cast of this type may have to be continued in adults for a period of 8 to 12 weeks before the adjacent callus is sufficiently heavy to permit removal of the plaster cast. Some atrophy of the muscles and soft tissues as a result of the immobilization may necessitate change of this plaster during this interval. If the cast becomes too loose, it should be changed in order to keep it as snug as possible. A word of warning should be given. A plaster cast of this type should be made as light as possible. A heavy cast used as a hanging cast will often stretch the soft tissue structures about the shoulder to such an extent that some subluxation of the head of the humerus may occur. This should be watched closely and if this tendency is observed, a sling or even a light Velpeau support may be added over the plaster cast.

THE ELBOW AND FOREARM

Certain injuries about the elbow may be managed safely by the physician in general office practice. Undisplaced fractures of the medial or lateral epicondyle, of the coronoid process, and of the olecranon process fall into this group. Fractures of this type usually should be immobilized in a plaster of paris cast with the elbow flexed to approximately 90 degrees for a period of three or four weeks. The institution of active exercise and active use of the extremity prior to this time carries with it some risk of displacing the fracture fragments. In fractures of this type in which displacement has occurred, open reduc-

tion and internal fixation are usually indicated, and the patient in such instances should be referred to an orthopedist.

Traumatic dislocations of the elbow may be treated by the physician in his office and often without the aid of a general anesthetic. As in traumatic dislocations of the shoulder, the patient should be given preliminary morphine or Demerol, and the patient should be permitted to relax until this has taken full effect. With the patient prone on the examining table, the involved extremity may hang in a dependent position at the side of the table and traction of 6 or 8 pounds may be added by simply having the patient hold a weight of this size in the hand. Occasionally, spontaneous reduction of the elbow will occur with this management. If this fails, additional mild traction and manipulation of the elbow may be safely added. If this fails, however, the patient should be given a general anesthetic in order to obtain complete relaxation of the soft tissue structures about the elbow to avoid the necessity of great force in reducing the dislocation. Once the dislocation has been reduced, a long arm plaster cast should be applied with the elbow flexed to 90 degrees. This plaster should be continued for three weeks. After its application roentgenograms should always be repeated in order to establish the fact that anatomic reduction of the elbow has occurred without injury to the adjacent bone structures. Once the plaster cast has been removed, active exercise and active use of the extremity should be instituted as rapidly as possible. Maintaining immobilization for this period of time seems to decrease the possibility of progressive calcification and ossification in the damaged soft tissue structures and in the hematoma about the elbow joint.

A simple fracture of the head of the radius or a fracture of the neck of the radius in which there is no marked comminution and no marked displacement of the fragment may be managed conservatively in the office of the general practitioner. If the comminution or displacement of the proximal portion of the radius is not sufficient to justify open reduction, it is not necessary to immobilize the extremity in these injuries. A sling may be used for several days or until the acute pain has subsided. The use of an elastic bandage during the first few days may also give some additional comfort. Early active use of these extremities avoids scar fixation about the proximal radio-ulnar joint and usually will result in improved function.

In fractures of this type with little or no displacement active use of the extremity carries with it very little risk of further displacement of the fragments, and for that reason early active use and active exercise of the extremity are safe. If the radial head is badly displaced or badly comminuted, open reduction and excision of the involved fragments should be considered in the adult. In a child, accurate replacement of a displaced radial head may be possible and should be attempted. This is done in order to diminish the possibility of difficulty resulting from growth disturbance by loss of the proximal radial epiphysis. Surgery of this type obviously requires hospitalization and specialized care.

Simple fractures of one or both bones of the forearm may be managed by the general practitioner in his office if no marked displacement has occurred. If marked angulation of the fragments or marked displacement and overriding exist, office management of the fracture should not be attempted. In children some degree of displacement may be acceptable and a simple conservative program of therapy followed. Immobilization by means of a long arm plaster cast is advisable, and the use of a simple removable splint should not be trusted since displacement of the fragments may occur. When a long arm plaster cast is used, the patient should be examined at intervals of 24 hours during the first three or four days, since extreme swelling may follow. The plaster cast should be continued for a total of eight weeks or longer if roentgenograms at the end of that time fail to reveal satisfactory healing of the fracture.

The possibility of secondary circulatory disturbances should be kept constantly in mind in the management of any fracture about the forearm and elbow, especially in children. Extremities have been lost after satisfactory reduction of fractures in these areas when the physician has failed to follow the patient closely and observe the secondary circulatory changes which have occurred. In the event of circulatory disturbance as manifested by intense swelling and cyanosis or in the event of intense pain which makes it impossible for the patient to sleep, the plaster cast should be split.

The Colles' fracture represents another type of injury which may be handled at times in the office of the general practitioner, keeping in mind the prerequisites outlined previously. The Colles' fracture is not a simple injury, and accurate reduction is at times difficult to obtain and maintain. In those instances when an orthopedist is not readily available, the physician in general practice may safely undertake treatment with the aid of local anesthesia. After questioning the patient as to sensitivity to procaine, 5 cc. of 1 per cent procaine is injected into the hematoma about the fracture site. It is usually best to insert the needle into the area of fracture over the dorsal or lateral aspect of the fracture site, and blood from the hematoma should be evacuated before the procaine is injected.

After allowing a few minutes for the procaine to take full effect, the fracture is then reduced by placing traction on the hand and pressure on the dorsal surface of the distal radial fragment with the thumb

over this point. After reduction of the fracture, immobilization should be carried out by means of a long arm plaster cast extending from the fingertips to the midportion of the arm with the elbow flexed to 90 degrees. The wrist should be immobilized in a position of flexion and ulnar deviation in an attempt to lock accurately the distal fragment of the radius in position.

The plaster cast is extended initially to the tips of the fingers and thumb in order to control the swelling in these parts. The cast is then trimmed to a point just proximal to the metacarpophalangeal joints at the end of about 72 hours in order to permit active exercise and active use of the digits during the remainder of the period of immobilization. The long arm plaster cast is usually continued for four weeks, at the end of which time a short arm plaster cast may be substituted. The position of flexion and ulnar deviation may be safely corrected at this time. This is in turn continued for two weeks so that the total period of immobilization involves approximately six weeks in any Colles' fracture. It is also advisable during this period to repeat the roentgen-ray study once or twice. If the position of the fragments has been lost, consultation with an orthopedist should be obtained.

THE HAND AND FOOT

Fractures of the metacarpals and fractures of the fingers and thumb in the majority of instances can be adequately managed in the office of the general practitioner. Fractures of the metacarpals are often oblique or spiral in type, and the transverse fractures often remain in satisfactory alignment. In such instances the use of a short arm plaster cast extending from the metacarpophalangeal joints proximally to the junction of the upper and middle thirds of the forearm should be applied and continued for four weeks. Transverse fractures of the neck of the metacarpal, in which there may be some depression of the corresponding metacarpal head, may be safely managed in this manner by simply forcing the depressed metacarpal head into satisfactory position during the time the plaster cast is setting. Such fractures more frequently involve the fifth metacarpal head than any other, and the plaster should be extended distally to incorporate most of the proximal phalanx of the involved digit.

Most fractures of the phalanges can be managed safely by the physician in general practice. Even if some angulation or displacement has occurred, manipulation and realignment of the phalanx is usually not too difficult. The most important point in the management of any fracture of the finger or thumb is to remember that it should be immobilized in a position of function. This necessitates fixation in a position of moderate flexion. If a finger is immobilized in complete extension as in the use of an ordinary tongue-blade splint, the finger is in a strained position and a series of angulations occurs at the various joint structures. Flexion of this finger to about 30 degrees represents a position of comfort and anatomic alignment. This position of immobilization may be maintained by means of a plaster of paris cast or it may be maintained by the application of any removable metal splint to the finger involved. Ordinary strips of ½ inch Duralumin may be easily obtained and kept in the office of the physician and cut to the desired length. This splint may be molded to the degree of flexion desired, adequately padded adjacent to the flexor surface of the finger, and held in position by means of narrow strips of adhesive tape. In most fractures it is usually advisable to superimpose a bandage type dressing in order to prevent removal of the splint and possible loss of position. The splint should be continued for three or four weeks in the majority of instances, but the exact length of time must be determined by the appearance of the individual fracture and the evidence of bony union as seen in the films.

Fractures of the lower extremity which may be managed by the physician in his general office practice are usually limited to the leg and foot. Simple fractures of the fibula and some fractures of the tibia remain undisplaced and nothing is indicated in treatment except the application of a plaster cast. In some instances this cast may extend only to the knee, but in the case of fractures of the tibia extension of the cast to the mid-thigh for immobilization of the knee is usually desirable in order to avoid the possibility of subsequent displacement. In any fracture of this type the plaster cast should be continued until roentgenograms have shown adequate bony union. This usually requires a minimum of six to eight weeks.

Undisplaced fractures of the malleoli may be managed by the simple application of a short leg plaster cast for a period of approximately six weeks. A word of caution, however, should be given in evaluating a fracture of this type. If there is any evidence of separation at the site of the fracture of the medial malleolus, it is possible that soft tissue has been interposed. In this type of problem, open reduction, removal of the interposed soft tissue, accurate approximation of the fracture fragments, and internal fixation are usually required. If a fracture of the medial malleolus does not remain in anatomic alignment, consultation with an orthopedic surgeon should be obtained immediately. If an open reduction is to be carried out in a fracture of this type, it should be done as early as possible before fibrosis of the interposed soft tissue and organization of the adjacent hematoma have occurred.

Simple fractures of the foot such as fractures of the metatarsals and fractures of the phalanges often require no plaster fixation. Unless multiple fractures have occurred or unless there is marked displacement of the fragments, a leather sole shoe usually will serve as adequate splinting and immobilization. In adults, a fracture of this type may be followed by extreme disuse bone atrophy, known as Sudeck's atrophy, if plaster immobilization is continued for several weeks. It is also possible in some instances to control the initial pain by the use of crutches for a few days without the necessity of plaster immobilization. If a plaster cast is applied, a walking heel should be added so that early weight bearing may be instituted. This frequently will help to prevent the disuse bone atrophy which may otherwise follow complete immobilization and loss of function over a period of a few weeks.

THE SPINE

A mild compression fracture of the spine may be managed by the physician through his office or with the patient at home without the necessity of prolonged hospitalization. Frequently encountered are mild compression fractures which usually involve the superior articular surface of one vertebra. Experience has shown that in the majority of instances attempted reduction of this fracture and fixation by means of a body cast will not bring about a great deal of permanent improvement. In most instances the original position of this fracture will again be assumed after the plaster has been removed. It is, therefore, unnecessary to hyperextend and completely immobilize a mild compression fracture of the spine. The patient may be simply kept in bed at home for 10 days to three weeks or until the acute pain has subsided. After this period the patient may be gotten up in an ordinary low back corset, lumbosacral support, or a Taylor back brace. A Taylor back brace is advisable if the fracture involves the thoracic portion of the spine, but the low back support will be adequate for any involvement in the lumbar area. The support should be continued for approximately three months at which time it usually can be discontinued if roentgenograms show satisfactory healing of the fracture. Simple fractures of the pelvis with little or no displacement of the fragments also can be managed in this way, and hospital beds can be reserved for those patients with more serious problems.

SUMMARY

An attempt has been made to discuss many of the simpler fractures and dislocations which can be adequately and safely managed in the office of the general practitioner. The plan of recommended treatment for each type of injury has been presented briefly. The general practitioner in the office management of these injuries should recognize his limitations. He should not attempt the treatment or management of compound fractures. He should not attempt the treatment of those fractures which involve neighboring joint structures or have associated soft tissue injuries which may be considered serious in type. The general practitioner should not attempt the management of that fracture which is badly displaced and in which open reduction and internal fixation can and will afford a more satisfactory result. In instances of this type the physician in general practice should request consultation with an orthopedic surgeon.

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Simple Method of Elevation of the Arm and Hand In Children

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THE MANAGEMENT of edema of the arm and hand in children, usually due to trauma or infections, commonly includes wrapping the upper extremity with elastic bandage, elevation on pillows,

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A regular 3 inch stockinette has been used successfully for maintaining elevation of the upper extremities of children in more than 100 cases of upper extremity infections and injuries (excluding fractures). The method described has many advantages, including that it permits activity and complete ambulation if the stand is on wheels.

and application of moleskin adhesive with traction type of elevation, slings, or casts. Most of these types of management are limited by the inability to maintain proper elevation of the extremity because of the excessive activity of the child. If ice packs or hot packs are to be applied, it is difficult to maintain them in the desired position. The following method has been used successfully at the Robert B. Green Memorial Hospital for maintaining elevation of the upper extremities of children without the disadvantages of many other methods.

The materials which are used are simple and are readily available in any hospital. They are:

1. Regular 3 inch stockinette, length as needed.
2. Adhesive tape, three strips 1 inch wide and 5 inches long.
3. Intravenous stand, one metal type stand 6 feet tall.
4. Gauze, 4 inches wide, length as needed.

Fig. 1. A child with her arm properly elevated by use of a stockinette.

a. The patient in bed.

b. The patient sitting in bed with no changes in adjustment of the apparatus since the child changed from the lying position to the sitting position.

c. The patient having changed to the standing position with no readjustment of the apparatus.

d. The posterior arrangement of the apparatus.

5. Rubber band, made from the bead on a discarded rubber glove.

If elevation is desired after specific and systemic treatment of the injured arm or hand have been instituted, then the following is done:

1. The arm is measured from the shoulder to the finger tips.
2. A piece of 3 inch stockinette 6 inches longer than the previously mentioned measurement is obtained, open at both ends.
3. The stockinette is slipped on the affected arm until the arm is enclosed up to the shoulder.
4. The upper end of the stockinette is taped to the thorax, not the arm, with the 1 inch wide strips of tape in such a manner that no circumferential constrictive tape is applied.
5. The free end of the stockinette is tied securely to the gauze.
6. The gauze is then attached to the intravenous stand with the rubber band. The length of the gauze is adjusted to elevate the arm properly.

The stockinette in place, with the arm elevated, is shown in figure 1.

When used properly, this method offers many advantages:

1. The arm is maintained in an elevated position regardless of the activity or position of the child.
2. The patient may be completely ambulatory and the arm elevated if an intravenous stand with wheels is used. The patient easily moves the stand around with the uninjured arm and hand.
3. The fingers, wrist, elbow, and shoulder are not completely immobilized and can be exercised as desired.
4. Ice packs or hot packs can be applied to any desired area, and they stay in position satisfactorily. These are usually placed in plastic bags of some type before they are put in the stockinette.
5. In most cases there is no need to place constricting elastic bandages, which are often uncomfortable, around the arm or hand.
6. If it is desired to place an elastic bandage about the arm, this can be done easily under the stockinette.
7. Very little maintenance and observation by the nursing staff is needed to maintain the elevation of the arm.

This method of elevation has been used in more than 100 cases of upper extremity infections and injuries (excluding fractures); and it has been found to be convenient, safe, and very satisfactory. Wrapping the extremity with elastic bandages to control swelling has not been found necessary. The method has been used successfully, also, in treating adults.

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Management Of Uremia

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THE MANAGEMENT of a patient manifesting an elevation of the nonprotein nitrogen level of the blood, commonly referred to as uremia, necessitates the determination, first of all, of the nature of the disturbance responsible for the observed accumulation of nitrogenous waste products in the blood. Such failure of the kidney may be a consequence of three general types of disorder: (1) a functional disturbance secondary to changes occurring outside of the urinary tract, usually designated as extrarenal or prerenal azotemia; (2) an acute failure of renal function; and (3) chronic disease of the kidney which has progressed to the point at which adequate excretion of nitrogenous waste products no longer can occur. The management of each of these three general types of renal disturbance is radically different and hence the need for evaluating the nature of the disturbance in any given patient.

Dr. Arthur Grollman, professor and chairman, Department of Experimental Medicine, The University of Texas Southwestern Medical School, presented this paper for the Section on General Practice, April 30, 1957, at the annual session of the Texas Medical Association in Dallas.

The rational management of a patient manifesting an elevation of the nonprotein nitrogen level of the blood necessitates first the determination as to whether the condition is due to acute renal failure or chronic renal insufficiency or whether it is extrarenal in origin. Proper treatment is radically different for these three general types of renal disturbance.

ETIOLOGY

Extrarenal azotemia is the consequence usually of a deficit of circulatory blood volume or extracellular-fluid volume which results in a deficient renal circulation and inadequate renal function. The condition usually follows dehydration, sodium loss, hemorrhage, or shock and results in only a moderate elevation of

the blood urea level unless the precipitating factors are of sufficient severity to induce acute renal failure. The management of extrarenal failure is directed obviously not at the kidney but at correcting the basic cause of the disturbance and is usually easily reversible.

The same fundamental causative factors are responsible for the development of acute renal failure as of extrarenal azotemia except that the precipitating causes are usually more severe and the renal failure results in oliguria or anuria. Moreover, in acute renal failure, the ischemia of the kidney is of such severity as to result in morphologically evident damage of the kidney which necessitates a period of a week or more for its repair. Correcting the original cause of the disturbance, therefore, must be done with sufficient promptness to prevent the development of tubular necrosis. Acute renal failure also may be observed at times in acute glomerular nephritis and other serious involvements of the renal parenchyma or its vascular supply. The treatment of acute renal failure has been described in detail elsewhere[3] and need not be considered further here.

Chronic renal insufficiency may result from various causes, most commonly from glomerulonephritis and pyelonephritis in which disorders the patient is usually seen after the disease has been present for many years and has given rise to irreversible changes in the kidney. However, chronic renal failure may occasionally also result from developmental anomalies, vascular disorders, metabolic disturbances, obstructive or infiltrative lesions, poisoning, and infections. The recognition of these disturbances is obviously important since, at times, surgical or other corrective measures can be utilized to ameliorate the condition or at least prevent its progression. The recognition of infectious processes in the kidney is particularly important now that we have available measures for obliterating them. In general, patients with obstruction, hydronephrosis with residual urine, and infection offer a prognosis which is much more hopeful than is reflected for a similar degree of uremia due to other causes.

In many cases of chronic renal failure, however, little repair can be anticipated, and the problem of management involves merely improving the function of the remaining renal tissue and correcting the abnormalities induced by the renal disturbance. The latter are of great importance, for the kidney not only is concerned with excreting waste products but is also essential for maintaining homeostasis in the organism insofar as salt and water balance and acid-base equilibrium are concerned.[5] Correction of the deviations in these functions not only permits more efficient renal function but also aids in symptomatic improvement of the patient.

PROGNOSIS

The condition of the pale, apathetic, and ofttimes semicomatose patient with uremia who presents himself to the physician should never be deemed hopeless nor treated by the symptomatic use of sedatives and "judicious neglect."[2] Even in patients who appear to be in the last stages of renal decompensation, partial reversal of the condition is often possible if the various factors contributing to the patients' condition can be recognized and treated on sound physiologic principles.[5] Such patients may have at least months, if not years, added to their life and at the worst may be kept more comfortable during the remainder of their life.

Although the high level of urea in the blood seen in uremia is in itself not harmful, it serves as a useful clinical index of the capacity of the kidney to perform its proper functions. Fully two-thirds of both kidneys must be removed before the urea concentrating power of the kidney is impaired. The quantity of urea formed and excreted is related to the amount of protein metabolized, and its excretion is in direct proportion to the amount filtered by the glomeruli.[6]

PREVENTIVE MEASURES

In disorders which result in chronic renal insufficiency, early treatment may prevent fatal uremia. Thus a large percentage of patients with chronic gout succumb to renal insufficiency. Adequate therapy with uricosuric drugs[4] may avoid this complication.

Disturbances in which calcium deposits occur in the kidney and result in diffuse nephrocalcinosis are also preventable. This complication may result from the excessive ingestion of calcium and alkali, the so-called "milk alkali disease," the ingestion of toxic doses of vitamin D, and hyperparathyroidism. Removal of the causative agent in these cases will lead to marked improvement in renal function. Potassium depletion is also damaging to renal function and should be avoided. The deposition of hyalin material in the Kimmelstiel-Wilson syndrome, secondary to diabetes, such chronic infections as syphilis and bacterial endocarditis, multiple myeloma, and amyloid disease also may result in chronic renal failure and may terminate in death from renal insufficiency. In all of these conditions, obviously, attention to the primary disease is necessary if one is to avoid or ameliorate renal dysfunction.

GENERAL THERAPEUTIC MEASURES

Rest.—Bed rest as an adjunct to the treatment of uremia is based on the fact that renal blood flow and the rate of glomerular filtration are increased in the

recumbent as opposed to the sitting or standing position. Thus recumbency may improve renal function. Reduced activity of course also reduces the rate of protein catabolism, which in turn reduces the load on the excretory function of the kidneys.

Diet.—The administration of a high protein diet in experimental renal insufficiency has been shown to precipitate renal decompensation. In the normal animal, also, a high protein diet increases the size of the kidney, presumably by increasing its work load. These observations have led to the advocacy by some of a low protein diet, but the value of reducing the protein intake in chronic nephritis is controversial. From a practical standpoint, the ingestion of excessive amounts of protein by the patient is rarely a problem, since appetite is usually poor and nausea is a frequent complication of uremia. It is usually more difficult to ensure an adequate protein and caloric intake to maintain a good nutritional state. Hence, it is unnecessary to subject the patient with uremia to the onerous task of careful restriction of diet. It must be remembered that such restriction, if drastic, may itself entail a burden on the organism and cause renal damage, particularly if the diet is lacking in lipotropic factors. A normal diet with adequate protein to compensate for renal loss as well as to maintain an optimal nutritional state would appear to be most appropriate for these patients. The use of antiemetic drugs, such as chlorpromazine or its congeners, and the avoidance of dehydration are helpful in counteracting nausea and anorexia.

SPECIFIC THERAPEUTIC MEASURES

Factors contributing to further renal impairment in uremic patients which are amenable to treatment include congestive heart failure, dehydration, infection, obstruction, salt depletion, alkalosis, anemia, potassium deficiency, and hypercalcemia. Since a small fraction of the total renal tissue suffices to maintain reasonable function, salvage of a relatively small amount of renal tissue, in a patient with rapidly advancing uremia, may allow renal compensation with a gain of at least months of comfortable and useful life.

Heart Failure.—Patients with congestive failure manifest signs of renal insufficiency as evidenced by the albuminuria, casts, and red blood cells observed in their urine. However, the urine is usually of high specific gravity and the nonprotein nitrogen level rarely exceeds 50 to 60 mg. per 100 cc. In the patient with chronic renal disease, the additional burden of a failing heart may make the difference between renal decompensation and progressive uremia. If hypoalbuminemia is also present, edema formation is aggravated. Digitalization and other measures which improve cardiac function are accordingly indicated in patients manifesting cardiac failure.

Hypertensive cardiovascular disease is a common accompaniment of renal disease. Measures effective in lowering the blood pressure often result in a further deterioration of renal function and hence must be used with caution.

Infection.—Infection of the urinary tract may contribute to the development of renal insufficiency by destruction of functional nephrons and also may aggravate an already compromised renal function and further compromise the limited renal reserve by an acute superimposed interstitial swelling. A search should therefore always be made in the uremic patient for the presence of infection and an attempt made to eradicate it by the available chemotherapeutic agents.

The coliform group of gram-negative organisms are found in about two-thirds of all urinary infections. Escherichia coli and Aerobacter aerogenes are usually found; of less common occurrence but more serious are the infections by Proteus vulgaris and Pseudomonas aeruginosa. Gram-positive staphylococci are also frequently found in the urinary tract, with the coliform group serving as secondary invaders.

Active destruction of renal tissue by pyelonephritis may progress without such clinical evidences of an acute infection as chills, leukocytosis, or such symptoms as dysuria, urinary frequency, and tenderness in the costovertebral angle. Considering the qualitative nature of the routine examination of the urine, even the absence of bacteria or white blood cells as ordinarily reported does not exclude the possibility of infection. For this reason a culture of a specimen of urine obtained by catheterization should be made. The use of indwelling bladder catheters and the urinary stasis of long-standing diabetes or neurologic disorders often lead to a persistent stubborn urinary tract infection.

For the greatest efficiency in treatment, the causative organism should be identified and intensive therapy with the most appropriate antibiotic instituted. Often when a given agent fails, others or a combination will prove successful.[4] The sulfonamides and antibiotics appear to act synergistically in this respect, but none are effective in the presence of continuing obstruction, stone, stricture, or other conditions contributing to chronic infection.

Systemic infections likewise as well as starvation, fever, and injury due to any cause will accelerate azotemia by increasing the breakdown of protein so that the control of these conditions may permit the kidney to regain its compensation. Superimposed infection is not uncommon in renal disease and may lead to manifestations suggesting impending death. With proper treatment, even such terminal conditions as pericarditis may disappear, the nonprotein nitrogen

level may be markedly reduced, and the patient may be restored to a relatively normal condition.[7]

Electrolyte and Water Balance.—Since the kidney normally is concerned with the maintenance of normal water and electrolyte metabolism,[5] patients with chronic renal insufficiency often suffer from derangements in salt and fluid balance which lead to serious symptoms of complaint. Dehydration in particular is often present and leads to a vicious cycle of further deterioration. The decrease in extracellular fluid resulting from dehydration leads to a decrease in glomerular filtration rate and a diminution in the rate of urine flow, which diminishes in turn the excretory efficiency of the already compromised kidney. This results in an accumulation of the nitrogenous waste products as well as of inorganic acids with a resultant acidosis, nausea, and vomiting, which in turn further deplete the extracellular fluid.

It is also to be remembered that the polyuria and nocturia of chronic renal insufficiency will initiate morning dehydration with its associated nausea. In such patients, therefore, the administration of hot milk or coffee immediately upon awakening or some other carbohydrate drink may often prevent a bout of intractable vomiting in the morning.[2] Chlorpromazine in a dose of 10 to 25 mg. given on awakening as well as a half hour before lunch is also frequently useful in combating this troublesome symptom. The acidosis which accompanies uremia probably also contributes to this nausea and may be relieved by the administration of sodium bicarbonate. Drugs or procedures which induce dehydration should be carefully avoided in the uremic patient. For example, withholding breakfast while the patient is in the hospital in order to draw fasting blood samples or for the performance of a concentration test often precipitates a spell of vomiting and nausea and induces further renal decompensation.

The incapacity of patients with chronic nephritis to secrete a concentrated urine may be compensated for in part by excreting a large volume of urine. It is desirable therefore that the patient ingest sufficient fluid to excrete a maximal amount of urine. This may be insured by having the patient collect the daily urinary output in a jar which is marked at the desired volume and insisting that this volume be attained daily.[1] This is particularly important in warm climates where urinary output frequently is low. If the patient is not edematous, the use of salt containing drinks or salty foods or the administration of salt tablets to stimulate thirst and to replace the salt lost in the urine may be necessary. In patients with so-called "salt losing" nephritis, it is particularly essential that salt loss be replaced.

Frequently patients who are edematous when placed on a salt free diet first lose their edema but subsequently redevelop edema because of water excess with the symptoms characteristic of this condition. In these, the administration of ample amounts of salt is obviously necessary to avoid hyponatremia. The salt lost by gastrointestinal secretions in vomiting or diarrhea may lead to salt depletion, and this as well as that lost by profuse sweating or other extraneous losses must be rigidly replaced. The use of mercurial diuretics in patients with congestive failure on a low salt diet may lead to hyponatremia and should be avoided for this reason as well as because of their potential toxicity.

Anemia.—Severe anemia is one of the characteristic changes observed in late stages of chronic renal insufficiency. This is due to an increased destruction of red blood cells and by a depression of the rate of red cell formation due, according to recent studies, to a deficiency of an erythropoietic principle elaborated by the kidney. In many patients with chronic nephritis, the rapid recurrent development of anemia may be the chief presenting problem. The anemia places a load on the circulatory system by increasing the cardiac output and reduces renal function by decreasing renal blood flow and glomerular filtration rate. Palpitation, dyspnea, enfeeblement, edema, angina, and other signs of severe anemia supervene.

The anemia of renal insufficiency is usually normocytic and normochromic. It does not respond to iron or other hematinic agents and must be treated when necessary by periodic transfusions. The use of cobalt salts is of questionable rationale[5] and may cause or aggravate nausea and vomiting when used in effective doses. It must be remembered that a low hematocrit by increasing the filtration fraction through the glomeruli favors a more efficient renal function and hence in some respects may represent a compensatory phenomenon. For this reason the anemia should not be entirely corrected by attempting to restore the hemoglobin to its normal level. Instead, it should be corrected only to the point at which troublesome symptoms are overcome, thereby retaining the advantage of a low hematocrit on renal efficiency. Transfusion reactions are common in these patients, particularly those who have received many transfusions; these may be minimized by the use of washed red blood cells and by a slow rate of infusion. Transfusion with small amounts (150 ml.) of blood daily rather than with a single larger transfusion reduces the risk of a reaction.

SUMMARY

The proper management of the patient with uremia requires a knowledge of the etiologic factors responsible for the condition as well as of the resulting physiologic disturbances. Their recognition not only may serve to prevent progression of the disorder but

will contribute to the maintenance of the patient in a relatively comfortable and useful state for prolonged periods.

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The Bed Commode

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Houston, Texas

A removable mattress plug with bedpan shaped to fit the hole, its edge flush with the mattress, can simplify handling of bed patients.

FIVE YEARS AGO, a friend and patient of mine had a major surgical procedure in a local hospital. Following this surgery, he was more disturbed by the use of the bedpan, both physically and mentally, than he was from the surgical procedure itself.

During his convalescence, he devised a badpan in a mattress that would eliminate most of the usual discomforts caused by the use of the conventional bedpan.

I have used the bed commode in 25 surgical cases, and I have found it to be of great value and comfort in patients with back surgery, orthopedic patients in traction, obese patients, and patients who were unable to assist themselves in any way to get on a conventional bedpan. I, therefore, wish to call the attention of the medical profession to this ingenious arrangement of the mattress and the bedpan.

Figure 1a shows the mattress with the off center plug. The plug is removed and the bedpan is fitted into the hole in the mattress, the top being flush with the mattress (fig. 1b). The patient is then slid over the pan for eliminations and does not have to have any undue pressure on the back, or be disturbed from traction, or be lifted onto the pan by attendants.

Recently, a man in the terminal stage of metastatic sarcoma became absolutely helpless because of the multiple fractures from metastasis. With the use of the bed commode, it was possible for one attendant to care for him and take the usual measures for eliminations.

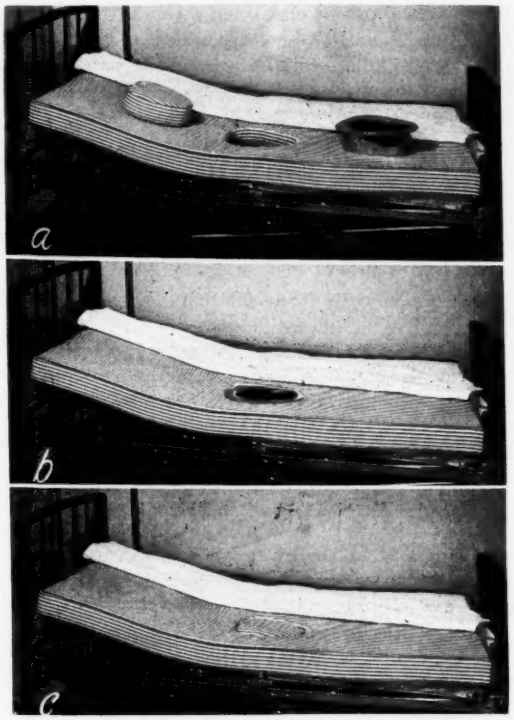

Fig. 1. The bed commode, showing (a) the off center hole with mattress plug and bedpan plug, (b) the bedpan in place (note edge flush with mattress), and (c) the mattress plug in place. The mattress was made by A. J. Shudde, Shudde Mattress Co., 1300 Main St., Houston.

Dr. Tucker, 610 Medical Arts Building, Houston 2.

CORRECTION: RADIATION PROTECTION

The title of table 1 in the article "Radiation Protection" by E. F. Gloyna, Dr. Eng, and Dr. J. C. Rude, published in the December, 1956, issue of the *Journal*, pages 853-860, should have read "Ionizing Radiation Experienced by the Patient Under Normal Conditions" rather than ". . . Experienced by the Physician. . . ." Reference to the table in the text should have been modified accordingly.

CLINICOPATHOLOGIC CONFERENCES

Case 2

MEDICAL STAFF, HARRIS HOSPITAL

Fort Worth, Texas

THE patient's chief complaints were back pain for 24 hours and cramping abdominal pain for six to eight hours. This was the third hospital admission for this 24 year old white Latin-American woman, gravida 5, para 3, whose last normal menstrual period was four to five months prior to this visit. Since her last normal period, she had had intermittent small bleeding episodes and one episode of suprapubic cramping. She had been seen regularly in the outpatient obstetric clinic for this and was placed on stilbestrol therapy of 25 mg. four times a day.

She was doing well until the night of admission, when she was seen in the emergency room for the complaints of back pain of an aching type, cramping abdominal pain, frequency of urination, and dysuria. She had a temperature of 100.4 F. She was thought to have a urinary tract infection and was given some Gantrisin and sent home.

Four hours later, the patient was seen again in the emergency room with the additional complaints of a severe shaking chill, vomiting, and increased temperature to 104.2 F. The vomitus was not remarkable. She also had slight vaginal bleeding at this time. The patient denied any attempt at abortion, denied any recent intercourse, and gave no history of epigastric pain.

A system review was negative except for mastitis of the left breast with a pregnancy five years before.

Her past history was negative. Previous hospital admissions had been for term pregnancies and normal deliveries.

Physical examination on admission revealed a temperature of 104.4 F.; pulse, 130 per minute; respiration, 24; and blood pressure, 110/60. The patient was a well developed, well nourished white woman about the stated age, oriented and cooperative, appearing acutely and severely ill, but not perspiring, nor cyanotic. There was no infection of her throat, nose, or ears and no evidence of blood in any of these passages. The thyroid was not palpable. There was no lymphadenopathy, no stiffness of the neck. The chest was bilaterally symmetrical; the breasts were normal; and the lungs were clear to percussion, palpation, and auscultation. No wheezes, rales, or rhonchi were present at this time. The size and shape of the heart were not noted. There was a tachycardia without a pulse deficit. Pulse was 130 per minute and regular. There was no notation of any murmurs.

There was generalized abdominal tenderness without rebound. The bowel sounds were decreased. A mass was palpated from the pubis to the umbilicus. The outlet to the pelvis was parous, with the uterus enlarged to a four to five month pregnancy. The cervix was blue and soft and free from any suggestion of bleeding at this time. The adnexa were clear. The extremities were free of edema. There was no evidence of thrombosis. Pulsations were present bilaterally. Deep tendon reflexes were normal. No abnormal reflexes nor leg stiffness were recorded. Bilateral costovertebral angle tenderness to percussion was noted.

Laboratory findings on admission revealed red blood cells 3,190,000 per cubic centimeter; hemoglobin 9.2 Gm. per 100 cc.; color index 0.90; hematocrit 29 volumes per cent; white blood cells 5,500 with a differential of 4 per cent monocytes, 3 per cent lymphocytes, 65 per cent segmented cells, and 28 per cent stabs. Urinalysis showed color yellow, trace of albumin, negative for sugar, character cloudy, and the microscopic study was negative. The serum was negative microscopically for hemolysis and the hemotest was negative. The VDRL test for syphilis was negative. Chest and abdominal roentgenograms were negative. The electrocardiogram was reported as normal.

Two hours after her admission to the hospital the patient's blood pressure was found to be 90/50. She was typed and crossmatched and given 2 pints of blood after which her hemoglobin was 13.3 Gm. per 100 cc. with a hematocrit of 40 volumes per 100 cc. Blood pressure was 85/50.

She had developed rather marked vaginal bleeding four hours after entry, and her pulse was still elevated to 120 per minute. Temperature at this time was 100.4 F. The cervix was found dilated with membranes bulging. Further examination revealed a low implantation of the placenta. A consultant considered this to be an inevitable abortion and possible pyelonephritis. The membranes were ruptured, and the patient was placed on antibiotics and oxytoxins and received another 500 cc. of whole blood.

Eight hours after entry, the patient passed a macerated fetus, placenta, and membranes. Bleeding ceased immediately following Ergotrate. She was given dicrysticin and another pint of blood following which the hemoglobin was 14.7 Gm. per 100 cc. and the hematocrit 44 volumes per cent. The white blood cell count showed 28,800 per cubic centimeter with a differential of monocytes 2 per cent, lymphocytes 7 per cent, segmented cells 41 per cent, stabs 47 per cent, juveniles 2 per cent, and eosinophils 1 per cent.

The patient continued to do poorly, however, and the blood pressure was 70/40, following the intravenous administration of 1 L. of fluid with Levophed, cortisone, and Achromycin.

Twelve hours after entry of the patient, midepigastric tenderness was extreme, but no splinting or guarding was noted. One observer felt there was dullness in the left flank at this time. A consultant suggested pancreatitis, but serum amylase was reported as 64 units. Levophed drip was continued; digitalization of the patient was completed; and antibiotic therapy was continued. The possibility of a transfusion reaction was suggested as well.

Twenty-one hours after entry, the blood pressure was not obtainable and the pulse was still very rapid. The patient complained of generalized pain and was in poor condition. She had developed moist rales in both lung bases at this time, and the respiration rate had increased with some cyanosis now present.

The patient's course progressively deteriorated, and 23 hours after entry, she frothed at the mouth and died.

CLINICAL DISCUSSION

DR. JOHN S. MARIETTA: When asked to participate in a clinicopathologic conference, I make several assumptions which are correct more often than not, and therefore help me face the ordeal with a greater

Participants in this conference were Dr. C. T. Ashworth (pathologist), Dr. John S. Marietta (internist), and Dr. J. G. Stouffer (obstetrician and gynecologist).

degree of equanimity. First of these assumptions is that the clinical diagnosis is difficult or there would be little point in presenting the case. Secondly, the problem is almost always unusual so that the pathologist may have an opportunity to present some interesting clinical information to the clinicians. Finally, the diagnosis lies within the field of my specialty—it would be inhumane, otherwise. With these points in mind, I find that the discussion concerns a pregnant woman.

The protocol gives three very definite and informative findings on which a diagnosis can be made. First, irreversible shock was present which appeared rapidly and persisted though normal values for the red blood count and hematocrit were quickly established. Second, the illness is characterized by a severe chill, fever, and a marked elevation of the white blood count. Third, death occurred within 24 hours of the onset of treatment. These findings are significant enough to rule out, at the beginning, hemorrhagic shock, neurogenic shock, and fluid and electrolyte imbalance. Other abnormalities associated with fetal death and the release of "toxic" materials into the blood stream are unlikely in view of the apparently normal response of the clotting mechanism.

Only two possibilities exist in this patient. First, and completely unsupported by the history, is the use of or exposure to some unnamed external toxin or drug which might produce this picture. Because of the lack of supporting evidence, I shall not pursue this further. The only other diagnosis which can be given serious consideration is that of an overwhelming bacteremia. The clinical picture of shock and infection make any other diagnosis unlikely.

It is necessary to attempt to determine the source of the bacteremia. Since the abdominal viscera, particularly the gastrointestinal and genitourinary tracts, are the common sources, they should receive special consideration. However, the search is seriously hampered by the presence of shock which limits the accuracy with which the patient can localize both pain and tenderness and may completely abolish muscle guarding. So a peritonitis following empyema of the gallbladder or an acute appendicitis must be considered. Acute pyelonephritis is also a possibility even in the absence of positive urinary findings. Though denied by the patient, attempted criminal abortion followed by infection is a definite possibility. However, we do not have enough information (and I do not know how it might have been obtained in this patient) to designate a primary source of the bacteremia, and I feel justified in leaving this diagnosis to the pathologist.

Another possibility might be that of a transfusion with grossly contaminated blood, but the transfusions were given only after shock appeared. There is nothing in the history to suggest that the patient had any generalized disease which would lower her resistance to infection such as diabetes, carcinoma, adrenal insufficiency, anemia, malnutrition, liver disease, or change in the serum proteins. Bacteremia often follows genitourinary or gastrointestinal surgery, which was not performed in this patient. My diagnosis must remain an overwhelming bacteremia, probably from a gram-negative organism from an undetermined site but without any coexisting constitutional disease which would decrease resistance to infection.

An excellent reference to this problem is contained in the *Archives of Internal Medicine*.[1] Since this report emanates from a veterans' hospital, the age group is older. Some 35 cases were reviewed with a reported mortality of slightly more than 50 per cent. It is interesting to note the quantitative culture findings ranged from 0.5 to 800 bacteria per milliliter of blood. Those patients having more than 100 bacteria per milliliter in the presence of shock did not recover. Unfortunately, this datum is not available in our patient. The clinical picture and the laboratory findings are almost identical to the description given in our protocol.

The therapy considered in this reference corresponds to the methods used in treating this patient. It is pointed out that shock decreases resistance to infection and that the mortality rate from experimental hemorrhagic shock is reduced when antibiotics are given. Patients with shock from bacteremia have little change in the blood volume, yet a small decrease in the volume may produce a marked lowering of the blood pressure. Vasopressor drugs are also recommended, but neither restoration of blood volume nor maintenance of blood pressure seem to have a significant effect on the mortality rate. Though direct adrenal involvement is unusual, steroid hormones are given, again without changing the eventual outcome. Digitalis is recommended only for rapid auricular fibrillation. Antibiotics are the mainstay of therapy and should be appropriate to the organism and given in sufficient quantity. Yet a Herxheimer reaction with a therapeutic paradox is likely due to the increased liberation of the endotoxin. The modes of treatment seem to leave much to be desired.

FURTHER CLINICAL DISCUSSION

DR. J. G. STOUFFER: There are two salient points in this case that are not mentioned in the protocol. The first point is that this Latin American woman and her husband had very poor command of the English language. As a result, the history was difficult to obtain, and at times the reliability of the history might be questioned. The second point is that about 12 hours after admission to the hospital, it was revealed that the patient had been hospitalized

one year previously because of "gallbladder trouble." Details could not be obtained; however, the husband volunteered that she was very sick at the time and her doctors expressed concern about her recovery.

The protocol tells us first of all that this patient apparently had an overwhelming infection with a temperature of 104.4 F. and a total white blood count of 5,500 per cubic centimeter with 65 per cent segmented cells and 28 per cent stabs.

Bilateral costovertebral angle tenderness suggests pyelonephritis. The negative microscopic urinalysis helps to exclude this, although pyelonephritis has been known to exist without pus being observed in the urine except in showers of cells.

The patient's low blood pressure combined with a rapid pulse would indicate shock—either due to acute blood loss, such as that from intra-abdominal bleeding or from bacteremia with toxins. The fact that her red blood count remained elevated after transfusions would fail to support the diagnosis of shock from blood loss.

I would interpret her vaginal bleeding with subsequent cervical dilatation and bulging fetal membranes as being Mother Nature's way of relieving the patient of the stress of pregnancy in the presence of overwhelming infection—intrauterine and/or systemic infection.

Clinically, the picture changed about 12 hours after admission when midepigastric tenderness was noted to be "extreme." With the additional history of previous gallbladder disease, serious consideration must be given to this organ. The possibility of acute gangrenous cholecystitis with perforation and bile peritonitis might well explain the findings in this case.

The diagnosis of pancreatitis also must be entertained, although one would expect the serum amylase to be higher than 64 units.

The patient's course over her 23 hours of hospitalization before death suggests infection which was caused either by an organism resistant to the antibiotics administered or by an infection which was so overwhelming that antibiotics did not have opportunity to overcome it. The response of the host appears to have been one of acute adrenal cortical insufficiency and vascular collapse in spite of vasopressors and cortisone therapy.

The presence of systemic infection in a pregnant woman who is experiencing vaginal bleeding and lower abdominal pain must always make one think of intrauterine infection. Interference with the pregnancy is usually denied by the patient and her family. Although pelvic examination showed no evidence of previous manipulation, it cannot be excluded.

From the beginning then, the onset of intermittent vaginal bleeding; suprapubic cramping followed by chills, fever, and in turn profuse vaginal bleeding; and delivery of a macerated fetus, coupled with a picture of shock, suggests that some type of vaginal manipulation was performed in an attempt to terminate the pregnancy. Shock which did not respond to repeated blood transfusions after the establishment of a satisfactory red blood cell level would help rule out uterine perforation. I would then favor the diagnosis of overwhelming septicemia with acute adrenal cortical insufficiency, secondary to intrauterine infection from criminal interference. My second choice would be acute gangrenous cholecystitis with perforation and bile peritonitis.

CLINICAL DIAGNOSIS

DR. MARIETTA: My diagnosis is gram-negative bateremic shock, with the primary site of infection undetermined.

DR. STOUFFER: My diagnosis is overwhelming septicemia with acute adrenal cortical insufficiency, secondary to intrauterine infection.

AUTOPSY FINDINGS

DR. C. T. ASHWORTH: The gross findings at autopsy were not very revealing. The lungs were remarkable, however (fig. 1a), presenting a dark reddish-blue discoloration, somewhat more marked in the dependent portions, and having a firm, noncrepitant consistency. They were reddened and exuded a moderate amount of slightly bloody edema fluid on pressure. The right lung weighed 600 Gm. and the left weighed 570 Gm. I considered these lungs to be typical of the change which has been described as "liver lung," the specific histopathologic aspects and physiologic disturbances of which will be given later. The only other striking finding at autopsy was the hypertrophied uterus (fig. 1b), resembling in size a four months' pregnancy. The uterus was boggy and contained some decidual and placental remnants. Although microscopic examination revealed an acute endometritis, grossly definite evidence of significant inflammatory involvement could not be seen.

Of particular significance in our study of this case is the growth of Pseudomonas aeruginosa from the blood stream. This finding developed after the death of the patient and for this reason was not mentioned in the clinical summary. In conjunction with the clinical aspects of the case and the gross findings, I consider this to be indicative of a true bacteremia, and the development of bacteremic shock. Many of the features of the case are entirely characteristic of the syndrome described as gram-negative bacteremic shock.

The demonstration of a marked acute inflammation of the endometrium and myometrium (fig. 1c) and the acute salpingitis in the presence of the recent

Fig. 1. Autopsy findings. a. Gross photograph of left lung revealing extensive vascular engorgement and dark discoloration due to hemorrhage and hyperemia.

b. Enlarged uterus with hemorrhagic endometritis and hypertrophy of recent pregnancy.

c. Photomicrograph of uterus, showing acute diffuse endometritis and myometritis.

d. Lung, showing marked alveolar capillary hyperemia. The alveoli are filled with protein precipitate of edema fluid and with fibrin deposits.

e. Myocardium, showing focal hyaline necrosis of muscle fibers with local accumulation of polymorphonuclear leukocytes (Zenker's hyaline necrosis).

f. Adrenal cortex, showing focal degeneration and necrosis of adrenocortical cells of zona fasciculata and tubularization of adrenal cortical cords.

abortion indicate rather clearly that there was an overwhelming Pseudomonas infection at these sites, followed by blood stream invasion and the production of a state of bacteremic shock due to the effects of the organisms and their products in the blood.

Some interesting features of the case were revealed by the histologic sections, relating to the pathophysiology of the pulmonary changes and the systemic effects of bacteremic shock.

In the lungs, there was found an unusual degree of alveolar capillary engorgement with blood. In most areas, small alveolar hemorrhages with abundant edema fluid were found. The unusual transudation is manifested further by the presence of a heavy protein content and the presence of fibrin in the alveoli (fig. 1d). There is reason to believe that the capillovenous congestion in the lungs, with edema and fibrin transudation, is due to a combination of injury of the capillary walls by the bacteria and their products and of injury of the myocardium resulting in backward left ventricular failure. It is probable that the segregation of blood and plasma fluid in the vessels and alveoli of the lung accounts in part for the shock produced and for the hemoconcentration which occurred. Certainly the filling of the air spaces of the lung as shown would be sufficient in itself to cause death.

Grossly, the myocardium was not unusual in appearance. However, on microscopic study, there were seen multiple small foci of focal degeneration and focal necrosis (fig. 1e). The dead muscle fibers had become hyalinized and leukocytes collected around them. Most of the muscle fibers of the heart were swollen as a result of parenchymatous degeneration. Fat stains showed no fatty degeneration probably because death occurred too rapidly to allow time for fat to accumulate. These changes in the heart muscle are similar to the myocardopathy seen in diphtheria and to the foci of Zenker's necrosis so typical of typhoid fever. Evidently, overwhelming gram-negative bacteremia can cause similar myocardial damage. It is believed that the amount of myocardial injury represented by these histologic changes would be significant in leading to a decreased cardiac output and peripheral circulatory failure, as well as leading to increased pulmonary hydrostatic pressure.

Other significant parenchymal cellular injury was demonstrated microscopically as focal necroses in the liver, hydropic degeneration and tubularization of the adrenal-cortical cell cords (fig. 1f), and an acute endothelial and epithelial degeneration in the glomeruli of the kidneys. These changes are considered to be due to a specific injurious effect of the bacteria and their products upon specialized parenchymal cells. It is not difficult to interpret these parenchymal degenerative changes as significant factors in the pathogenesis of the physiologic disturbances which characterize the phenomenon of gram-negative bacteremic shock.

The pathologic diagnoses are:

1. Pseudomonas bacteremia with bacteremic shock.
2. Marked pulmonary edema and hyperemia.
3. Focal necrosis and parenchymal degeneration of heart, liver, adrenals, and kidneys.
4. Acute endometritis at site of recent abortion and acute salpingitis.

A further evaluation of the mechanism of production of the clinical picture of shock and death in this case was carried out by Dr. R. G. Harding, Jr., who performed the autopsy and studied this case from the pathologic standpoint. To confirm the pathogenicity of the Pseudomonas organism grown from the blood culture in this case, cultures of the organisms were prepared and injected into four rabbits. Heat killed organisms and live organisms were used, with and without polymyxin B. All rabbits were then observed over a period of 72 hours. All displayed temperature elevations to 106 or 107 F. and 2 of the rabbits died, 1 of which received heat killed organisms without polymyxin B, and the other of which received live organisms without polymyxin B. The cause of death in both rabbits appeared to be a shocklike syndrome. Histologic sections of the lungs (fig. 2) displayed a picture of massive vascular engorgement similar to that observed in the patient.

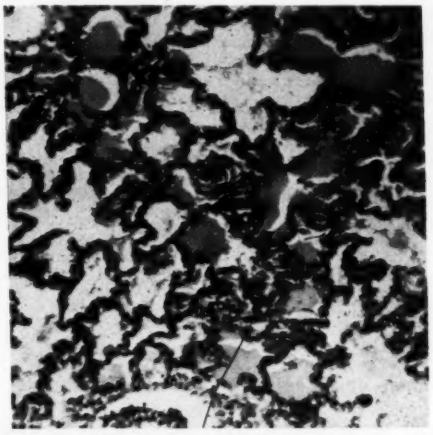

Fig. 2. Photomicrograph of lung of rabbit dying of shock following injection intravenously of a suspension of Pseudomonas aeruginosa isolated from patient's blood. There is marked alveolar capillary engorgement and pulmonary edema.

REFERENCES

1. Hall, W. H., and Gold, D.: Shock Associated with Bacteremia; Review of Thirty-Five Cases, Arch. Int. Med. 96:403-412 (Sept.) 1955.
2. Spittel, J. A., Jr.; Martin, W. J.; and Nichols, D. R.: Bacteremia Owing to Gram-Negative Bacilli: Experiences in Treatment of 137 Patients in 15-Year Period, Ann. Int. Med. 44:302-315 (Feb.) 1956.

MEDICAL NEWS

★ Coming Meetings

Texas Medical Association, Houston, April 19-23, 1958 (Executive Council, Sept. 8, 1957). Dr. Denton Kerr, Houston, Pres.; Mr. C. Lincoln Williston, 1801 North Lamar Blvd., Austin, Executive Secy.

American Medical Association, Interim Meeting, San Francisco, April 10-12, 1958. Dr. Dwight H. Murray, Napa, Calif., Pres.; Dr. George F. Lull, 535 North Dearborn, Chicago 10, Secy.

Current Meetings

JULY

American Congress on Maternal Care, Chicago, July 8-12, 1957. Dr. F. Bayard Carter and Dr. Samuel B. Kirkwood, 116 S. Michigan Ave., Chicago 3, Co-Chm.

Fifth and Sixth Districts Society, Corpus Christi, July 5-6, 1957. Dr. James C. Sharp, Corpus Christi, Pres.; Dr. Winston E. Riley, 2400 Morgan, Corpus Christi, Secy.

Twelfth District Society, July 9, 1957. Dr. George C. Bryant, Waco, Pres.; Dr. J. T. Archer, Jr., Meridian, Secy.

Postgraduate Medical Assembly of South Texas, Houston, July 15-17, 1957. Dr. C. Forrest Jorns, 412 Jesse H. Jones Library, Houston 25, Secy.

AUGUST

No meetings have been reported for August.

National and Regional

American Academy of Allergy, Philadelphia, Feb. 3-5, 1958. Dr. W. B. Sherman, New York, Pres.; Dr. Francis C. Lowell, 65 E. Newton, Boston, Secy.

American Academy of Dermatology and Syphilology, Chicago, Dec. 7-12, 1957. Dr. Nelson P. Anderson, 2007 Wilshire Blvd., Los Angeles 5, Pres.; Dr. James R. Webster, 55 E. Washington, Chicago 2, Secy.

American Academy of General Practice, Dallas, Spring, 1958. Dr. Malcom E. Phelps, El Reno, Okla., Pres.; Mr. Mac F. Cahal, Volker Blvd. at Brookside, Kansas City 12, Executive Secy.

American Academy of Obstetricians and Gynecologists, Los Angeles, April 21-23, 1958. Dr. R. Gordon Douglas, New York, Pres.; Dr. John C. Ullery, Ohio State University Hospital, Columbus, Secy.

American Academy of Ophthalmology and Otolaryngology, Chicago, Oct. 13-18, 1957. Dr. Erling W. Hansen, Minneapolis, Pres.; Dr. W. L. Benedict, 100 First Ave. Bldg., Rochester, Minn., Secy.

American Academy of Pediatrics, Chicago, Oct. 7-10, 1957. Dr. Edgar E. Martmer, Grosse Point 30, Mich., Pres.; Dr. E. H. Christopherson, 1801 Hinman Ave., Evanston, Ill., Secy.

American Association for Thoracic Surgery, Boston, May 16-18, 1958. Dr. Brian Blades, Washington, D. C., Pres.; Dr. Hiram T. Langston, 600 S. Kingshighway, St. Louis 10, Mo., Secy.

American Association of Genito-Urinary Surgeons, Edgewater Park, Miss., April 23-25, 1958. Dr. George F. Cahill, New York, Pres.; Dr. W. J. Engel, 2020 E. 93rd, Cleveland, Secy.

American Association of Obstetricians and Gynecologists, Hot Springs, Va., Sept. 5-7, 1957. Dr. F. Bayard Carter, Durham, N. C., Pres.; Dr. E. Stewart Taylor, University of Colorado School of Medicine, 4200 E. 9th, Denver, Secy.

American Cancer Society, New York, Oct. 30-Nov. 1, 1957. Dr. D. A. Wood, San Francisco, Pres.; Mr. M. R. Runyon, 521 W. 57th, New York, Executive Vice-Pres.

American College of Allergists, Atlantic City, April 20-25, 1958. Dr. Merle Moore, Portland, Ore., Pres.; Dr. David Thomas, 1467 Harper St., Augusta, Ga., Secy.

American College of Chest Physicians, San Francisco, June 18-22, 1958. Dr. Burgess L. Gordon, Philadelphia, Pres.; Mr. Murray Kornfeld, 112 E. Chestnut, Chicago 11, Executive Secy.

American College of Gastroenterology, Boston, Oct. 20-23, 1957. Dr. Arthur A. Kirchner, Los Angeles, Pres.; Mr. Daniel Weiss, 33 West 60th, New York 23, Executive Director.

American College of Physicians, Atlantic City, April 28-May 2, 1958. Dr. Walter L. Palmer, Chicago, Pres.; Mr. E. R. Loveland, 4200 Pine, Philadelphia 4, Secy.

American College of Radiology, Chicago, Feb. 5-8, 1958. Dr. Ira H. Lockwood, Kansas City, Pres.; Mr. W. C. Stronach, 20 N. Wacker Dr., Chicago 6, Executive Director.

American College of Surgeons, Atlantic City, Oct. 14-18, 1957. Dr. Daniel C. Elkin, Lancaster, Ky., Pres.; Dr. Michael L. Mason, 40 E. Erie, Chicago 11, Secy.

American Congress of Physical Medicine and Rehabilitation, Los Angeles, Sept. 8-13, 1957. Dr. A. B. C. Knudson, Washington, D. C., Pres.; Dr. Frances Baker, 1 Tilton Ave., San Mateo, Calif., Secy.

American Dermatological Association, Sun Valley, June 4-8, 1958. Dr. Clark W. Finnerud, Chicago, Pres.; Dr. Hamilton Montgomery, 200 1st, S.W., Rochester, Minn., Secy.

American Gastro-Enterological Association, Washington, D. C., May 30-31, 1958. Dr. M. W. Comfort, Rochester, Minn., Pres.; Dr. F. J. Ingelfinger, 65 E. Newton, Boston 18, Secy.

American Gynecological Society. Dr. Norman F. Miller, Ann Arbor, Mich., Pres.; Dr. A. A. Marchetti, 3800 Reservoir Rd., N.W., Washington 7, D. C., Secy.

American Heart Association, Chicago, Oct. 25-29, 1957. Dr. Edgar V. Allen, Rochester, Minn., Pres.; Mr. John D. Brundage, 44 E. 23rd, New York 10, Secy.

American Hospital Association, Atlantic City, Sept. 30-Oct. 4, 1957. Dr. Albert W. Snoke, New Haven, Conn., Pres.; Dr. Edwin L. Crosby, 18 E. Division, Chicago, Executive Director.

American Laryngological, Rhinological, and Otological Society, San Francisco, Calif., 1958. No 1957 meeting. Dr. Percy E. Ireland, Toronto, Ont., Canada, Pres.; Dr. C. S. Nash, 277 Alexander, Rochester 7, N Y., Secy.

American Neurological Association, Atlantic City, June 16-18, 1958. Dr. Israel S. Wechsler, New York, Pres.; Dr. Charles Rupp, 133 S. 36th, Philadelphia 4, Secy.

American Ophthalmological Society, White Sulphur Springs, W. Va., May 28-30, 1958. Dr. Walters Atkinson, Watertown, N. Y., Pres.; Dr. M. C. Wheeler, 30 W. 59th, New York 19, Secy.

American Orthopedic Association. Dr. David M. Bosworth, New York, Pres.; Dr. Harold A. Safield, 715 Lake St., Oak Park, Ill.

American Pediatric Society. Dr. Daniel C. Darrow, Mission, Kan., Pres; Dr. A. C. McGuinness, 1427 I St., N.W., Washington 5, D. C., Secy.

American Proctologic Society, Los Angeles, June 29-July 3, 1958. Dr. Julius E. Linn, Birmingham, Pres.; Dr. Norman D. Nigro, 10 Peterboro, Detroit 1, Secy.

American Psychiatric Association, San Francisco, May 12-16, 1958. Dr. Harry C. Solomon, Boston 15, Pres.; Dr. William Malamud, 80 E. Concord, Boston 18, Secy.

American Public Health Association, Cleveland, Nov. 11-15, 1957. Dr. John W. Knutson, Washington, D. C., Pres.; Dr. R. M. Atwater, 1790 Broadway, New York 19, Executive Secy.

American Society of Anesthesiologists, Los Angeles, Oct. 14-19, 1957. Dr. Irving M. Pallin, Brooklyn, Pres.; Dr. J. E. Remlinger, Jr., 188 W. Randolph, Chicago 1, Secy.

American Society of Clinical Pathologists, New Orleans, Sept. 29-Oct. 4, 1957. Dr. J. L. Goforth, Dallas, Pres.; Dr. Clyde G. Culbertson, 1040-1232 W. Michigan, Indianapolis 7, Secy.

American Surgical Association, New York, April 16-18, 1958. Dr. John Mulholland, New York, Pres.; Dr. William Altemeier, Christian R. Holmes Hospital 19, Cincinnati, Secy.

American Urological Association, New Orleans, April 29-May 1, 1958. Dr. William J. Baker, Chicago, Pres.; Dr. Samuel L. Raines, 188 S. Bellevue Blvd., Memphis, Tenn., Secy.

Association of American Physicians and Surgeons, Interim Meeting of Delegates, Oct. 18, 1957. Dr. Cyrus W. Anderson, Denver, Pres.; Mr. Harry E. Northam, 185 N. Wabash Ave., Chicago 1, Executive Secy.

International College of Surgeons, U. S. Chapter, Chicago, Sept. 9-12, 1957. Dr. Curtice Rosser, Dallas, Pres.; Dr. Karl Meyer, 1516 Lake Shore Dr., Chicago, Secy.

National Tuberculosis Association, Philadelphia, May 24-29, 1958. Dr. William M. Morgan, Alliance, Ohio, Pres.; Mrs. Wallace B. White, 1790 Broadway, New York 19, Secy.

Radiological Society of North America, Chicago, Nov. 17-22, 1957. Dr. C. Edgar Virden, Kansas City, Pres.; Dr. Donald S. Childs, 713 E. Genesee, Syracuse 2, N. Y., Secy.

Southern Medical Association, Miami Beach, Nov. 11-14, 1957. Dr. J. P. Culpepper, Jr., Hattiesburg, Miss., Pres.; Mr. V. O. Foster, 1020 Empire Bldg., Birmingham 3, Secy.

Southern Psychiatric Association, Nassau, Oct. 6-8, 1957. William H. McCullagh, Jacksonville, Fla., Pres.; Dr. Joseph L. Knapp, 210 N. Westmoreland, Dallas, Secy.

Southern Surgical Association, White Sulphur Springs, West Va., Dec. 10-12, 1957. Dr. Floyd W. McRae, Atlanta, Pres.; Dr. George G. Finney, 2947 St. Paul, Baltimore, Secy.

Southwest Allergy Forum. Dr. Truman C. Terrell, Fort Worth, Pres.; Dr. Sim Hulsey, 701 Fifth Ave., Fort Worth, Secy.

Southwest Regional Cancer Conference, Fort Worth, Sept. 20-21, 1957. Dr. O. L. Morphis, 815 Medical Arts Building, Fort Worth, Chm.

Southwestern Medical Association, Houston, March 31-April 2, 1958. Dr. Kenneth C. Sawyer, Denver, Pres.; Dr. C. M. O'Leary, 207 Plaza Court Bldg., Oklahoma City, Secy.

Southwestern Society of Nuclear Medicine. Dr. Henry H. Turner, Oklahoma City, Pres.; Dr. J. R. Maxfield, Jr., 311 Medical Arts Bldg., Dallas, Secy.

Southwestern Surgical Congress. Dr. C. M. O'Leary, 207 Plaza Court Bldg., Oklahoma City, Secy.

Tri-State Medical Assembly, Shreveport, Sept. 12-13, 1957. Dr. H. O. Padgett, Marshall, Pres.; Dr. Jason Sanders, Sanders Clinic, Kings Highway, Shreveport, La., Secy.

State

Private Clinics and Hospitals Association of Texas. Dr. J. P. Anderson, Bradv, Pres.; Mr. C. H. Rugeley, Wharton, Secy.

Texas Academy of General Practice, Dallas, Sept. 22-25, 1957. Dr. George V. Launey, Jr., Dallas, Pres.; Mr. Donald C. Jackson, 1905 N. Lamar, Austin, Executive Secy.

Texas Academy of Internal Medicine, Houston, December, 1957. Dr. Jay C. Crager, Beaumont, Pres.; Dr. Hugo T. Engelhardt, 1216 Main, Houston, Secy. Meetings restricted to members.

Texas Air-Medics Association, Houston, April, 1958. Dr. W. D. Marrs, Fort Worth, Pres.; Dr. C. F. Miller, P. O. Box 1338, Waco, Secy.

Texas Association of Blood Banks. Dr. C. D. Fitzwilliam, Fort Worth, Pres.; Miss Marjorie Saunders, 3707 Gaston Ave., Dallas, Secy.

Texas Association of Obstetricians and Gynecologists, Galveston, February, 1958. Dr. Arthur M. Faris, Houston, Pres.; Dr. Oran V. Prejean, 4317 Oak Lawn, Dallas, Secy.

Texas Chapter, American Association of Public Health Physicians. Dr. Roy G. Reed, Victoria, Pres.; Dr. A. R. Doane, 410 E. 5th, Austin, Secy.

Texas Chapter, American College of Chest Physicians. Dr. John A. Wiggins, Fort Worth, Pres.; Dr. H. M. Anderson, 224 E. Harris, San Angelo, Secy.

Texas Club of Internists. Dr. Charles M. Darnall, Austin, Pres.; Dr. L. C. Carter, 2600 Procter, Port Arthur, Secy.

Texas Dermatological Society, El Paso, Oct. 12, 1957. Dr. Charles D. Stewart, Corpus Christi, Pres.; Dr. E. N. Walsh, 1310 Medical Arts Bldg., Fort Worth, Secy.

Texas Diabetes Association. Dr. H. T. Engelhardt, Houston, Pres.; Dr. Warren W. Moorman, 901 W. Leuda, Fort Worth, Secy.

Texas Division, American Cancer Society, Austin, Dec. 5-6, 1957. Dr. Porter Brown, Fort Worth, Pres.; Mr. Curt W. Reimann, 5014 Bull Creek Rd., Austin 3, Executive Director.

Texas Geriatrics Society, Houston, April, 1958. Dr. Martin S. Buehler, Dallas, Pres.; Dr. J. A. Armstrong, 3810 Swiss Ave., Dallas, Secy.

Texas Heart Association. Dr. James A. Greene, Houston, Pres.; Mr. Edgar M. Brown, 404 Jesse H. Jones Library Bldg., Texas Medical Center, Houston 25, Executive Director.

Texas Hospital Association. Bolton Boone, D.D., Dallas, Pres.; Mr. O. Ray Hurst, Executive Director, 2208 Main, Dallas, Secy.

Texas Industrial Medical Association, Houston, Sept. 26-28, 1957. Dr. Robert J. Potts, Houston, Pres.; Dr. Robert A. Wise, Box 2180, Houston, Secy.

Texas Neuropsychiatric Association, Dallas, Oct. 18-19, 1957 (with Central Neuropsychiatric Association). Dr. Bruce H. Beard, Fort Worth, Pres.; Dr. Clarence S. Hoekstra, 8215 Westchester Drive, Dallas, Secy.

Texas Ophthalmological Association. Dr. Thomas J. Vanzant, Houston, Pres.; Dr. Louis Daily, Medical Arts Bldg., Dallas, Secy.

Texas Orthopedic Association. Dr. Margaret Watkins, Dallas, Pres.; Dr. B. C. Halley, Jr., 524 Doctors Building, Dallas, Secy.

Texas Pediatric Society, Austin, Oct. 17-19, 1957. Dr. E. M. Wier, Fort Worth, Pres.; Dr. James N. Walker, 5216 W. Freeway, Fort Worth, Secy.

Texas Proctologic Society, Fort Worth, February, 1958. Dr. Hugh Beaton, Fort Worth, Pres.; Dr. C. P. Hardwicke, 920 E. 32nd, Austin, Secy.

Texas Public Health Association, Dallas, Feb. 23-26, 1958. Mr. J. N. Murphy, Jr., Austin, Pres.; Mr. H. E. Drumwright, City Health Department, Dallas, Executive Secy.

Texas Radiological Society, San Antonio, Jan. 24-25, 1958. Dr. T. G. Russell, Houston, Pres.; Dr. J. E. Miller, 6407 Forest Lane, Dallas 30, Secy.

Texas Rheumatism Association, Houston, Dec. 6, 1957. Dr. Jesse W. Hofer, Houston, Pres.; Dr. Warren W. Moorman, 901 W. Leuda, Fort Worth, Secy.

Texas Society for Mental Health, Houston, March 22-24, 1958. Dr. Virginia Love, Houston, Pres.; Mr. John Lane, 2510 San Antonio, Austin, Executive Director.

Texas Society of Anesthesiologists. Dr. J. D. McCulley, Houston, Pres.; Dr. Randle J. Brady, 3317 Binz, Houston, Secy.

Texas Society of Gastroenterologists and Proctologists. Dr. Tate Miller, Dallas, Pres.; Dr. O. P. Griffin, 1101 Medical Arts Bldg., Fort Worth, Secy.

Texas Society of Ophthalmology and Otolaryngology, Austin, Dec. 6-7, 1957. Dr. Owen R. O'Neill, Paris, Pres.; Dr. Edwin G. Grafton, 4319 Oak Lawn, Dallas, Secy.

Texas Society of Pathologists. Dr. Lloyd Hershberger, San Angelo, Pres.; Dr. Mervin H. Grossman, 3121 Bryan, Dallas, Secy.

Texas Society of Plastic Surgeons. Dr. Truman G. Blocker, Galveston, Pres.; Dr. Steve R. Lewis, University of Texas Medical Branch, Galveston, Secy.

Texas Surgical Society, Waco, Oct. 7-8, 1957. Dr. Truman G. Blocker, Galveston, Pres.; Dr. G. V. Brindley, Jr., Scott and White Clinic, Temple, Secy.

Texas Traumatic Surgical Society. Dr. Russell Holt, El Paso, Pres.; Dr. W. E. Crump, 1300 Eighth, Wichita Falls, Secy.

Texas Tuberculosis Association. Dr. Howard T. Barkley, Houston, Pres.; Miss Pansy Nichols, 2406 Manor Road, Austin, Executive Director.

Texas Urological Society. Dr. Jack Crow, Abilene, Pres.; Dr. Ian Thompson, John Sealy Hospital, Galveston, Secy.

United States-Mexico Border Public Health Association, Hermosillo, Sonora, Mexico, April, 1958. Malcolm H. Merrill, Berkeley, Calif., Pres.; Dr. Sidney B. Clark, 243 U. S. Court House, El Paso, Secy.

District

First District Society, February, 1958. Dr. W. A. Jones, El Paso, Pres.; Dr. E. S. Crossett, 309 Medical Arts Bldg., El Paso, Secy.

Second District Society. Dr. J. Vernon McKay, Lamesa, Pres.; Dr. Noble L. Rumbo, Box D, O'Donnell, Secy.

Third District Society, Amarillo, Spring, 1958. Dr. William Klingensmith, Amarillo, Pres.; Dr. H. Fred Johnson, 2308 W. Eighth, Amarillo, Secy.

Fourth District Society. Dr. Joe B. Stephens, Bangs, Pres.; Dr. S. H. Martin, 115 S. Park, San Angelo, Secy.

Seventh District Society. Dr. Robert N. Snider, Austin, Pres.; Dr. Richard Lucas, 502 W. 13, Austin, Secy.

Eighth District Society. Dr. E. Peter Garber, Galveston, Pres.; Dr. John Childers, Univ. of Texas Medical Branch, Galveston, Secy.

Ninth District Society, Conroe, Spring, 1958. Dr. Eugene M. Addison, Huntsville, Pres.; Dr. James H. Sammons, Highlands, Secy.

Tenth District Society, Port Arthur, Fall, 1957. Dr. Charles W. Castle, Liberty, Pres.; Dr. Richard O. Clements, 715 Main, Liberty, Secy.

Eleventh District Society. Dr. M. T. Braswell, Henderson, Pres.; Dr. Hugh F. Rives, Jacksonville, Secy.

Thirteenth District Society, Abilene, 1958. Dr. Roy Wilson, Seymour, Pres.; Dr. R. D. Moreton, 1217 W. Cannon, Fort Worth, Secy.

Fifteenth District Society. Dr. L. E. Rutledge, Daingerfield, Pres.; Dr. O. R. Taylor, Jr., Linden, Secy.

Clinics

Blackford Memorial Cancer Lectures, Denison, Nov. 5, 1957. Dr. John D. Gleckler, 211 N Fannin, Denison, Chm.

Dallas Southern Clinical Society, Dallas, March 24-27, 1958. Dr. C. D. Bussey, Dallas, Pres.; Miss Helga Boyd, Medical Arts Bldg., Dallas 1, Executive Secy.

International Medical Assembly of Southwest Texas, San Antonio, Jan. 27-29, 1958. Dr. John C. Parsons, 1125 Nix Professional Bldg., San Antonio, Secy.

New Orleans Graduate Medical Assembly, New Orleans, March 3-6, 1958. Dr. Eugene H. Countiss, New Orleans, Pres.; Dr. Maurice E. St. Martin, 1430 Tulane Ave., New Orleans 12, Secy.

North Texas-Southern Oklahoma Fall Clinical Conference, Wichita Falls, Oct. 19, 1957. Dr. Kenneth C. Bebb, 1518 10th, Wichita Falls, Chm.

Oklahoma City Clinical Society Conference, Oklahoma City, Oct. 28-30, 1957. Dr. Herman Fagin, Oklahoma City, Pres.; Miss Alma F. O'Donnell, 503 Medical Arts Bldg., Oklahoma City 2, Executive Secy.

State Tumor Conference, Wichita Falls. Dr. Edwin C. Bebb, 500 Broad St., Wichita Falls, Director.

Board Examinations

Texas State Board of Examiners in Basic Sciences. Henry B. Hardt, Ph.D., Fort Worth, Pres.; Mrs. Pearl A. Barrera, 407 Perry-Brooks Bldg., Austin, Chief Clerk.

Texas State Board of Medical Examiners, Fort Worth, Dec. 5-7, 1957. Dr. M. H. Crabb, 1714 Medical Arts Bldg., Fort Worth, Secy.

MEDICAL MEETINGS

American Fracture Association

The American Fracture Association will meet in El Paso September 30-October 2, and preceding the meeting (September 29) there will be a postgraduate course sponsored by the University of Texas Postgraduate School of Medicine, El Paso Division.

The postgraduate course will include the following discussions:

Fixation of Fractures of the Patella—Dr. Herbert E. Hipps, Waco.
Mechanical Principles Involved in Fixation of Fractures—Dr. Duncan McKeever, Houston.
External Fixation in Hand Surgery—Dr. William L. Waldrop, Oklahoma City.
Management of Problem Fractures by Transfixion—Dr. Roger Anderson, Seattle.
Fractures of the Nasal and Malar Bones—Dr. John B. Erich, Rochester, Minn.
Social and Psychological Significance of Scars—Dr. Robert T. McElvenny, Chicago.
Fat Embolism—Dr. Garrett Pipkin, Kansas City.
Intramedullary Fixation—Dr. Dana M. Street, Memphis, Tenn.

Following the course there will be a reception at the Hotel Cortez given by Dr. and Mrs. Ralph Homan and Dr. and Mrs. W. Compere Basom. Dr. Basom is chairman of the convention and program committee of the association, and Dr. Homan is director of the El Paso division of the Postgraduate School.

More than 20 physicians will present papers during the meeting of the fracture association, and there will be a round-table luncheon on Monday. For the ladies, there will be a tea, and a banquet dinner-dance is planned for Tuesday evening for the doctors and their wives.

Otolaryngology Assembly

The Department of Otolaryngology, University of Illinois College of Medicine, will have its annual assembly September 30-October 6. An intensive series of lectures and panels concerning advancements in otolaryngology, and evening sessions devoted to surgical anatomy of the head and neck and histopathology of the ear, nose, and throat will be held. Interested physicians may write to the department, 1853 West Polk, Chicago 12.

WHO Will Meet in U. S.

The World Health Assembly, governing body for the World Health Organization, has accepted an invitation to hold its 1958 session in the United States, but no city has been selected. Action was taken by the assembly at its meeting in Geneva. Congress extended the invitation last year, and authorized spending $400,000 to cover additional costs of the meeting here, away from WHO's permanent headquarters in Geneva.

Easter Seal Convention

The annual convention of the National Society for Crippled Children and Adults—the Easter Seal Society—will be held October 31-November 2 in Chicago. Specialists as well as lay personnel will participate in the meeting.

Pan-Pacific Surgical Association

The seventh congress of the Pan-Pacific Surgical Association will be held in Honolulu November 14-22. Brochures may be obtained from Dr. F. J. Pinkerton, Director General of the Association, Room 230, Young Building, Honolulu, Hawaii.

Ultrasonics in Medicine

The International Conference of Ultrasonics in Medicine will be held in Los Angeles September 6-7. Dr. John H. Aldes, 4833 Fountain Avenue, Los Angeles 29, can supply information.

Pheasant Hunt Combined with Medical Program

The South Dakota State Medical Association will sponsor the Hunter's Fall Medical Meeting during the first five days of pheasant hunting season in October. Designed for out-of-state doctors, the program will feature morning and evening scientific sessions, leaving the afternoons free for hunting. John C. Foster, Executive Secretary, 300 First National Bank Building, Sioux Falls, can provide all details.

Texas Academy of General Practice

Eight guest speakers will be featured during the meeting in Dallas of the Texas Academy of General Practice, September 22-25. Sunday, September 22, will be devoted to committee meetings, the annual business session, and election of officers. The scientific portion of the meeting will begin Monday and continue through noon Wednesday.

Guest lecturers will be Drs. Carlo Scuderi, Chicago; A. Clayton McCarty, Louisville; John H. Lawrence, Berkeley; Phil C. Schrier, Memphis; Fred M. Taylor, Houston; Philip Thorek, Chicago; Robert J. Booher, New York; and John A. Schindler, Monroe, Wis.

Preceding the assembly, the University of Texas Southwestern Medical School will offer a one day seminar on the collagen diseases at the medical school, Saturday, September 21.

The social program will include a joint luncheon for doctors and their wives Monday, a luncheon for the doctors Tuesday, and the President's Ball on Tuesday evening. The ladies may attend a special brunch and style show at Neiman Marcus, and a hospitality room for them will be open throughout the meeting.

OF GENERAL INTEREST

PERSONALS

Dr. J. R. Maxfield, Jr., Wichita Falls, conducted a symposium on radiation protection at the annual meeting in Oklahoma City of the Society of Nuclear Medicine late in June. *Dr. Maxfield* also was honored in May for his service to the National Foundation for Infantile Paralysis and for outstanding community service. A testimonial "This Is Your Life" program was held for him at a meeting of Rotary International in Wichita Falls.

Dr. Merton M. Minter, San Antonio, has been elected chairman of the board of governors of Southwest Foundation for Research and Education.

Dr. Henry Hoskins, San Antonio, now is governor for Texas of the American College of Chest Physicians. *Dr. George R. Herrmann*, Galveston, former governor, was made regent of the college.

Dr. Paul Burow, Killeen, is the new president of the Mid-Texas Heart Association.

Dr. Ruth Bain recently was chosen one of the four outstanding women of Austin by the Soroptomist Club.

Dr. Pearl Matthaei-Stabbert, San Antonio, was honored in May by the local chapter of Theta Sigma Phi, women's professional journalism fraternity, as the outstanding professional woman in the area.

C. V. Jones, Taft, died in Corpus Christi June 7. He was the father of *Drs. L. Bonham Jones* and *George W. Jones*, both of San Antonio. Four other children survive.

Dr. Collier Rucker, Jacksonville, heads a city beautification committee which has an unusual project, a "downtown color scheme," under way. Plans are to repaint utility poles, parking meter standards, street markers, and the exteriors of business buildings in harmonious colors, thus setting the pace for general improvement of the business district.

Dr. Herman I. Kantor, Dallas, presented a paper, "Complications of Tubal Plastic Surgery," at a recent meeting in New York of the American Society for the Study of Sterility. Dr. Kantor is an associate clinical professor of obstetrics and gynecology at Southwestern Medical School.

The late *Dr. J. Edward Hodges*, Houston, was honored with the awarding of the Hodges' Nursing Scholarship Fund by the Woman's Auxiliary to Harris County Medical Society in May. Two other scholarships for nursing students were presented by the auxiliary at the same time. All three students expect to attend nursing schools in Houston.

Dr. Howard G. Swann, Galveston, received a grant of $16,500 from the Life Insurance Medical Research Fund to continue his research on kidney infection.

Dr. L. M. Shefts, San Antonio, will tour the Pacific this summer as a consultant for the United States Army Surgeon General.

Dr. R. Lee Clark, Jr., Houston, has been appointed section chief by the American College of Surgeons' Committee on Cancer.

Dr. W. S. MacComb and *Dr. G. H. Fletcher*, Houston, reported on the combined use of surgery and radiotherapy in treatment of cancer of the larynx at the recent meeting of the American Radium Society in Quebec, Canada.

Dr. William S. Derrick, Houston anesthesiologist, has received the Alumni Achievement Award for 1957 from George Washington University, Washington, D. C.

Drs. Milton R. Hejtmancik, Galveston; *C. J. Quintanilla*, Harlingen; and *Katharine H. K. Hsu* and *Peron O. Jones*, Houston, received certificates of fellowship in the American College of Chest Physicians at that group's recent meeting in New York.

Dr. Curtice Rosser, Dallas, spoke at the eastern division meeting of the International College of Surgeons early in July in Dixville Notch, N. H. His topic was "Management of Polyps of the Large Bowel."

Dr. Louis Daily and *Dr. Louis J. Girard*, Houston, participated in the program of the fourth interim congress of the Pan-American Association of Ophthalmology and the 1957 conference of the National Society for the Prevention of Blindness, Inc., which were held in New York in April.

Mrs. Berenice W. Williston, mother of *C. Lincoln Williston*, executive secretary of the Texas Medical Association, died in Austin on July 3. Mrs. Williston, who had lived for 19 years in Champaign and Urbana, Ill., had been in Austin the past five months. Survivors other than her son are two brothers and two sisters, all residents of Missouri.

Dr. and Mrs. Charles Binney are the parents of a girl, Marguerite Louise, born February 26 in Harlingen. Laura May was born to *Dr. and Mrs. Edward Egbert* March 7 in El Paso, and a daughter was born to *Dr. and Mrs. John M. Prine* April 6 in Arlington. *Dr. and Mrs. Leroy Lockhart* are parents of twin girls born in Galveston in April. Robert Lee was born April 18 to *Dr. and Mrs. William Ghormley* in Corpus Christi; *Dr. and Mrs. Bernard Schnitzer* announced the arrival of Jeffrey April 26 in Dallas, and *Dr. and Mrs. Byron Spires* are parents of a son born in Galveston in April.

UNIVERSITY OF TEXAS BUDGET

The fifty-fifth Legislature has made appropriations which are included in the budgets for the University of Texas and its branches for 1957-1958. Authorized expenditures for the medical branches are as follows:

Medical Branch, Galveston, $8,926,546, compared with $7,867,389 last year.

Southwestern Medical School, Dallas, $1,988,940, compared with $1,650,705 last year.

M. D. Anderson Hospital and Tumor Institute, Houston, $5,109,117, compared with $4,783,488 last year.

Postgraduate School of Medicine, Houston, $63,828, compared with $46,548 last year. In this instance, no general revenue was involved in either year.

Vaccination Requirements For International Travel

The international certificates of vaccination form was revised in January to include changes of rules made at the Ninth World Health Assembly in 1956. The revision is designed to assist quarantine officials of various nationalities and language backgrounds to interpret readily and correctly the information on the forms. Also, a supplement to the booklet, "Immunization Information for International Travel" includes changes made in immunization requirements. The booklet and supplement are available from the Superintendent of Documents, Government Printing Office, Washington 25, D. C., at 25 cents per copy.

Doctors Had Part In Early Education

The University of Texas will celebrate its seventy-fifth year in 1958, and in observance of this anniversary, a collection of art and artifacts associated with campus life is being assembled in the Texas Memorial Museum in Austin. The first student to win a bachelor of arts degree from that school was Samuel Clark Red, who later became a physician. He received his diploma in 1885, and it now hangs in the Museum's Great Memorial Hall. Among the signers of this historic diploma were Dr. Ashbel Smith, first chairman of the Board of Regents and a leader in medical affairs, and Dr. Thomas D. Wooten, the regent who supervised construction of the first unit of the Old Main Building. Mrs. S. C. Red later established the George Plunkett Red student loan fund, which is administered by the Woman's Auxiliary to the Texas Medical Association.

TMA Members Active in AAPS

Several members of the Texas Medical Association also work with committees of the American Association of Physicians and Surgeons. Dr. Mylie E. Durham, Houston, serves on both the legislative and public relations committees; Dr. Carlos Fuste, Jr., Alvin, is a member of the committees on by-laws and finance; Dr. John K. Glen, Houston, works with

the delegates nominating committee and the finance committee; and Dr. Mal Rumph, besides serving as president-elect of the group, is chairman of the essay contest committee and a member of the newsletter committee. Dr. E. E. Anthony, Fort Worth, is chairman of the membership committee, and serving with him is Dr. Robert Jones, Lancaster. Drs. D. E. Neal, Fort Worth, and E. S. McLarty, Galveston, work with Dr. Rumph on the essay contest committee, and a third Texan on the finance committee is Dr. T. C. Terrell, Fort Worth.

Postoperative Infection Rate Rising

Hospital experts agree that surgeons and hospital operating teams must return to the old-fashioned scrub-up principles of Lister to combat a rising incidence of postoperative infections caused partially by overdependence on antibiotics. Development of bacterial strains resistant to antibiotics, increased hospital utilization, longer operations, and older patients also were mentioned as contributing factors to the number of infections.

The transcript of this panel discussion appears in the June 16 issue of *Hospitals*. Panelists include Dr. Mark H. Lepper, Chicago; Dr. Chester W. Howe, Boston; Sidney Liswood, Toronto; and Dr. Sarah H. Hardwicke, Chicago.

Techniques of surgical operations were named as the single most important item in postoperative infection. "All wounds are contaminated at operation, even under the best of conditions, so this is a matter of degree. How much it is contaminated, whether it gets infected or not, depends more on surgical technique than any one single factor," said Dr. Howe.

Mr. Liswood pointed out that increased infection was bound to occur when more and more people are hospitalized. The community brings diseases into the hospital, and hospitalization is much easier now than it was several years ago. Possible control measures discussed included admission of patients as close to the operation date as possible, and separation of patients just admitted from patients in the postoperative wards.

Oklahoma's Cavalcade of Health

The Cavalcade of Health, an exhibit sponsored by the Oklahoma State Medical Association was held during the time of the semicentennial birthday of Oklahoma June 14-July 7 in Oklahoma City. This exposition featured 42 booths designed to bring health education to the public. A special attraction was "Juno," a German-built exhibit. Her internal organs illuminate in sequence as her voice explains their function. More than 6 miles of wire compose her veins, visible through her plexiglas skin.

Competitions and Grants

Urology Award—The American Urological Association offers an annual award of $1,000 (first prize, $500; second prize, $300; third prize, $200) for essays on the result of some clinical or laboratory research in urology. The competition is limited to urologists who have been graduated not more than 10 years, and to hospital interns and residents doing research work in urology. Essays must be in the hands of William P. Didusch, 1120 North Charles Street, Baltimore, before December 1. Mr. Didusch can supply full details.

Caleb Fiske Prize—"Hormonal Relationships in Breast and Prostatic Cancer—Their Practical Application" will be the topic for this year's dissertation in the Caleb Fiske Essay Contest sponsored by the Rhode Island Medical Society. A cash prize of $350 will be awarded. Information regarding rules may be obtained from the Secretary, Caleb Fiske Fund, Rhode Island Medical Society, 106 Francis Street, Providence 3.

Leukemia Grant—The Leukemia Society will award grants-in-aid to support research projects on leukemia and allied diseases for 1957-1958. Various amounts will be awarded depending on the requirements of the investigators. Applications may be made throughout the year, and they should be received not later than May 15, August 15, November 15, and February 15 for the earliest possible consideration. The Leukemia Society, Inc., 27 William Street, New York 5, will accept applications.

Egg Bombs Show Safety Margin

"Operation Egg Drop," in which five fresh hen eggs dropped on absorptive pads from a height of 115 feet in the rotunda of Colorado's state capitol building, resulted in only one egg being broken. It landed on a crack between two sheets of padding. The yolk of one egg was broken, and the other three were intact after the fall.

The significance of these tests, a joint project of the Colorado State Medical Society and the Denver Police Department, is that when the human head strikes an object the force may not be enough to fracture the skull, but brain damage may result unless the energy absorption is particularly efficient.

Tests were first carried out in 1946; more than 10 years elapsed before practical application of these findings was made in the motorcars of America, and then, not as standard equipment. These studies were undertaken by the Colorado State Medical Society because many of its members believe that injury prevention is equally important with accident prevention. The recent demonstration proves that the human head can be protected if pads 1 to 2 inches thick are placed on those spots within the automobile where serious blows most often occur.

Dr. Sarnoff Gets New Heart Award

A new award for meritorious investigation in the field of cardiovascular disease and related topics has been established by the Jacobs Foundation of Dallas. The award, which carries with it a $1,000 honorarium, was instituted this year with a gift made jointly to the Dallas Heart Association and the University of Texas Southwestern Medical School by the Leslie L. and Helen F. Jacobs Foundation. Dr. Stanley Jay Sarnoff, chief of the laboratory of cardiovascular physiology of the National Heart Institute, Bethesda, Md., has been named the first recipient.

U. S. Alerted on Influenza Epidemic

The United States Health Service has issued statements that physicians should be on the lookout for influenza of the type that now is causing epidemics in the Far East. Tests show that the strain is strikingly different from any type A virus recovered heretofore.

Because of the number of travelers from the East, the disease may show up in this country at any time. All re-

spiratory disease outbreaks should be investigated immediately and reported promptly to the local health authorities, say state health officials. The Texas State Health Department is a cooperating laboratory in the fight against the disease, and antigens are available. During the first three days of illness, suspicious cases should be tested by submitting throat washings for laboratory tests. During the acute phase of illness, serum should be tested. Local health officers or individual physicians can forward samples to the State Health Department.

Scientists at the National Institutes of Health now are conducting tests on a newly developed vaccine for protection against the virus. State health officers have been furnished all details available on the disease; foreign quarantine inspectors at ports of entry are advising all travelers from the Orient and Philippines to see their physicians immediately if they develop respiratory illness within 10 days after arrival; and local health officers are being notified of the names and addresses of passengers who enter the country with a respiratory illness.

Amarillo Paper Wins Award

The Amarillo *Globe-Times* was chosen this year to receive the Texas award for the best editorial presentation of mental health and its impact on the community. This award is given by the Texas Society for Mental Health during Mental Health Week.

GP Survey Results Being Widely Quoted

The provocative results of an 18 month study of general practice conducted by a team of University of North Carolina physician-investigators in their home state and originally published in a special edition of *The Journal of Medical Education* should be required reading for all generalists, says Dr. John S. DeTar, former president of the American Academy of General Practice. The conditions revealed are probably representative of those throughout the country, he is quoted as saying in the May 6 issue of *Medical News*.

The study indicates that:

1. Only one general practitioner in four provides "above average" quality of medical care.
2. After age 35, there are definite signs of a leveling off in quality of practice by all generalists, regardless of training or educational achievement.
3. Only 55 per cent of physicians observed made a regular practice of having the patient sufficiently disrobed during physical examinations; two-thirds usually skipped a vaginal examination; only 52 per cent were credited with using the electrocardiograph competently; slip-ups in sterile technique were charged to 43 per cent.
4. The average general practitioner, at least in North Carolina, works 51 hours a week, earns $15,000 a year, sees 30 patients a day, doesn't worry about sending out statements and frowns on collection agencies. The more money he earns, the more medical journals he buys. Benefits of postgraduate study are "largely dependent on the individual's initiative."

$10,000 Grant for Religion-Mental Health

The National Academy of Religion and Mental Health has announced a grant of $10,000 from the Smith, Kline and French Foundation to provide fellowships for theological students and clergymen of all faiths who want to become chaplains in mental hospitals. A nonprofit organization founded in 1954, the academy is nonsectarian, includes 600 members of the American Psychiatric Association, 500 members of the American Psychological Association, 500 clergymen, and more than 400 psychiatric social workers, cultural anthropologists, educators, and laymen. It serves as consultant to hospitals, medical schools, and mental health groups in the United States and abroad.

Obstetrics, Gynecology Writing Awards Set

The Division of Obstetrics and Gynecology of the United States Section, International College of Surgeons, has announced that two awards will be made for best manuscripts not exceeding 5,000 words submitted by December 1, 1957. First prize will be $500, second prize, $300. Contestants must hold the degree of doctor of medicine from an accredited college of medicine; the two winners will be asked to participate in the scientific program at the 1958 annual congress of the United States and Canadian Sections, International College of Surgeons.

Details and manuscript forms may be obtained by writing Dr. Harvey A. Gollin, secretary of the Committee on Prizes, 55 East Washington Street, Chicago 2.

Texas Doctor on Liaison Committee

The American Psychiatric Association has set up a project to study ways by which a greater understanding of psychiatry can be conveyed to physicians in general practice. It is believed that the urgent need for expanding psychiatric services in communities throughout the nation can be met most readily and practicably by general practitioners armed with basic psychiatric knowledge.

A liaison committee with the American Academy of General Practice will serve the project in an advisory capacity, its membership including Dr. Andrew S. Tomb, Victoria.

Outlook Good for Mental Recovery

A considerable proportion of those who have had mental disorders severe enough to cause disability ultimately recover and are able to resume and maintain a fairly normal level of activity. The rate of recurrence of the disorders is relatively low and decreases as time goes on, and the record of survivorship after recovery from disability is comparatively favorable.

These are the encouraging facts gleaned from a recent study of policyholders by a major life insurance company's statisticians.

The study related solely to men and covered a period between 1925 and 1949. Statisticians point out that new and improved types of therapy which have been developed since the period covered make the outlook even more favorable, adding, however, that "the needs in this field are far from being met."

Premedical Conference Held

A conference to develop closer relationship between college premedical counselors and the medical schools in Texas was held under sponsorship of Baylor University and the University of Texas on the main campus of the University of Texas, Austin, May 11. Premedical advisers from several academic institutions of the state and representatives from the three medical schools presented formal addresses and led group discussions in which everyone attending the conference could exchange information and views.

Credit and Collection: Solving the Problem

A few years ago, so the story goes, a poorly dressed man visited a well known diagnostician in one of our large cities and requested a diagnosis of his case. The physician, being a generous soul interested in all humanity, took the case and called a colleague for consultation. An operation was deemed necessary. The patient, passing not as a pauper, but as a poor man, was charged a modest fee.

Five days later, in one of the best hospitals in the city, the man burst out laughing. To his nurse he said: "I'm just amused at the way I fooled your doctors. My physician told me this operation would cost me $500—but I'm getting it done for $100!"

The man was worth over a million dollars.

This anecdote may be only partially true, but it illustrates one of the reasons for the growing use of medical credit bureaus by doctors in Texas and across the nation.

On the other hand, a Texas doctor performed vital surgery on a patient with whom he never discussed fees in advance. When the patient received his bill for several hundred dollars, he was embarrassed to ask to pay it off at $10 or $15 a month. *So he didn't pay a cent.* Referred to a medical credit bureau by the physician six months later, the situation was resolved by one visit: the patient, really an honest man, was delighted to relieve his feelings of guilt by beginning payment in small monthly installments; eventually, he returned to the doctor for further care.

Again, an illustration of the advantages of such a bureau to the doctor member.

Pro and Con Opinions Flourish

All physicians, to be sure, do not use collection bureaus nor approve of them for reasons to be touched upon briefly later. (A survey* made in 1955 by Dr. J. S. DeTar, past president of the American Academy of General Practice, revealed that of 140 doctors queried, one-third disliked, and preferred not to use, such services ever.)

Yet, in at least four large Texas cities—Dallas, Houston, San Antonio, and Austin—medical credit and collection bureaus are being operated successfully, and doctors in smaller communities have been heard to wonder aloud whether some similar arrangement might work for them.

The need for these bureaus is two-fold, advocates say. One point involves money; the other, public relations.

Figures from the U. S. Department of Commerce show that the age of an account determines its value. After six months, for instance, each "accounts receivable" dollar is worth only 67 cents; after one year, only 45 cents; after two years, 23 cents; after three years, 15 cents; and after five years, 1 cent. Since a doctor's family has to buy groceries and usually expects to do so with money earned by his abilities, it is apparent he should attempt to collect as many of the accounts owed him as possible.

But doctor-patient relations are also a major factor.

If an account is not paid because of a misunderstanding which leaves the patient feeling he has been overcharged, if a patient is in unusual financial straits which he is too embarrassed to explain to the physician, or if the patient is a known "deadbeat" who owes numerous doctors and businesses and whose account is sure to become a bad debt—the physician should know. (In the last mentioned case, it would have been to his advantage to have known the first time the patient appeared in his office.)

Though using similar operating methods and charging approximately the same commissions, the bureaus to be mentioned here are set up in a variety of ways.

Charm Works Best, Travis Society Believes

The Travis County Medical Service Bureau, for instance, is a branch of the Travis County Medical Society. Of its three functions, the credit and collection portion is only one, the others being a telephone answering service and an employment service for medical assistants. In the first six months of its existence, the credit bureau made 7,000 contacts and had $200,000 worth of accounts turned over to it, most of these a year old. About half the county society members use it.

The Travis bureau employs three full-time and two part-time collectors, and, says executive secretary Charles Collum, "We have found that nice, charming, middle-aged ladies suit the job best. Some young men, for example, are inclined to be too aggressive from the public relations standpoint. . . ."

In certain cases, one telephone call from the bureau suffices to secure collection, and in some, one home visit by a collector will accomplish the desired end. When the bureau makes collections, its commissions are scheduled thus: 25 per cent, accounts 90-120 days overdue; 33⅓ per cent, 120-180 days overdue; and 50 per cent, more than 180 days overdue, out-of-town, and so on.

But, repeats Mr. Collum, "If a bureau can do nothing but collect money for the doctor, it is not worth the time and effort. It *must* serve as a public relations device."

For Dallas M.D.'s: Business Classes

The Dallas Doctor's Bureau, a division of the Merchants Retail Credit Association of Dallas, was started in January, 1932, by the then local manager of the association, with the approval of Dallas County medical and dental societies.

Vision, courage, and know-how were required to pioneer in any field in those bleak depression days, and the Dallas group considers that the chief reason for the success of the venture was its organizational structure. The MRCA was then 35 years old; the Doctor's Bureau had immediate access to the then 500,000 credit records in the association files; it could obtain credit reports from almost every part of the world; its personnel was already highly trained in credit reporting and investigating; and, finally, it had available for members the Red Book, the consumer rating book published by the association.

In the beginning, costs of operating the Doctor's Bureau were borne by the Merchants Retail Credit Association. After about five years, it was able to pay its own way. Now, its membership exceeds 700 physicians and dentists, and association files have grown to include a million and a half records.

Since its earliest days, the Doctor's Bureau has conducted classes in business management for doctors' offices—classes attended by physicians, their secretaries, and business managers. It has taught the Dallas doctor that an account properly opened is half collected and that patients welcome an open discussion of fees.

In instances in which an account becomes past due, the doctor or his secretary calls the bureau to learn if there have been changes in the financial status and paying habits of the debtor. Later, if the account requires collection help from outside sources, he may use several of the collection aids supplied him by the bureau at a nominal fee. Also, he lists his accounts in the bureau's central files so that they will be included in future credit reports to association members.

*DeTar, J. S.: *What 140 M.D.s Think of Collection Agencies, Medical Economics, Sept., 1955, pp. 255-262.*

Frequently, persons who have been declined credit at stores or whose applications for home loans have been rejected will call at the offices of the association to learn what unpaid accounts are listed on their records. Often they pay these accounts in order to clear the records. For this service, the Doctor's Bureau makes no charge to its members.

The Dallas bureau, in addition, has a "locate service" for members through which lost addresses of patients and reports on those who have moved out of town are handled. (The biggest problem facing the Dallas bureau today, that office reports, is in getting the doctor to know the value of credit reports on all new patients. "The time to learn of a poor financial condition or patient attitude was when the case was first accepted and the patient eager to make satisfactory arrangements to pay the doctor's fee.")

Commenting on the Dallas bureau, Millard J. Heath, executive secretary of the county society, adds, "It has been our policy here for a number of years not to set up or operate any services for physicians that were handled satisfactorily by private enterprise."

"This type of service should be rendered by the normal business institutions in the community that supply credit information to normal retail businesses, department stores, etc.," declares a Dallas doctor, "so that a large number of people are available for information on the patient's paying habits. That is tied up with the normal business functions of the community rather than with doctors or county societies."

Bexar Bureau Endorsed by Society

In San Antonio, Business and Professional Service—a privately-owned business specializing in professional credits and collections—is the official credit bureau endorsed in June, 1956, by the Bexar County Medical Society. As such, it is successor to a bureau known as the Medical Exchange and Information Service, Inc., which the society owned from 1931 to 1941, but which it dissolved that first year of World War II.

As a member of the National Association of Medical-Dental Bureaus, Inc., Business and Professional Service has had good cooperation from the doctors in listing their delinquent accounts, but, adds Ferne McKenzie Wood of the staff, "the use of the medical clearance service has not as yet been sufficient to make it profitable. We have had less than 100 inquiries during any month, which makes it very expensive in operational costs because it necessitates expensive help to operate; however, we feel that the availability of a medical clearance service rounds out our services to the profession and justifies the maintenance of such a department in our organization."

"Our experience over the past 16 years," she continues, "has been that the professional man is not primarily interested in a credit report in the commercial sense, but rather in being able to obtain immediate information as to the manner in which a medical account might be expected to be treated as an obligation of the patient."

Houston Doctors Financed Own Bureau

In Houston, the Medical and Dental Service Bureau, Inc., was organized in 1936 as a compulsory-membership group: all members of the Harris County Medical Society were obliged to belong, inasmuch as its first funds were raised by assessment on society members. Later, the Houston District Dental Society was invited to join on a similar basis. Eventually, 20 physicians and dentists borrowed $10,000 to supplement the original operating capital, the sum being repaid out of earnings of the bureau.

In 1940 membership became purely voluntary, and today members of the medical and dental societies have a choice of types of memberships, depending on the services they desire. Approximately 1,250 physicians and dentists are now affiliated.

Ownership of this organization, which is nonprofit, is vested in the Houston Academy of Medicine and the Houston Academy of Dentistry, the division being about 85 and 15 per cent, respectively.

Financial growth of the Houston bureau has been consistent, additional capital being set aside year by year to meet city growth. Present assets are more than $300,000—consisting largely of notes held by the bureau from patients who have sought financial aid to defray medical, dental, and hospital expenses. (The actual money has been paid by the bureau to the physicians, dentists, and hospitals.)

The Houston bureau offers its members eight services: (1) telephone locating service, (2) telephone secretarial service, (3) loans to patients, (4) centralized bookkeeping, (5) collection, (6) employment and placement, (7) credit information, and (8) social service.

The collection service department brings in more than $100,000 annually in professional delinquent accounts. Commissions of 50 per cent of the amount collected is charged on all accounts, except in instances in which a member refers $5,000 or more annually to the department; then, it is only 33⅓ per cent.

General membership in the bureau costs a doctor or dentist $9 a year. He pays extra for telephone locating or telephone secretarial services, and if he uses the central bookkeeping system, newest bureau service, cost is predicated on volume of accounts receivable.

Service—to doctor and patient alike—is the bureau's only real commodity. An example of its value to the community is the fact that each month the bureau receives applications for loans from some 300 families unable to meet sudden heavy medical or dental expenses; of these, about 250 loans per month are granted, and recovery on loans averages 98 per cent.

Phoenix Bureau Collects $31,000 a Month

Nationally recognized as one of the most successful organizations of this kind is the Bureau of Medical Economics, a service organization of the Maricopa County Medical Society in Phoenix, Ariz.

Organized in 1951 with the assistance of a $6,000 loan from the medical society, it was self supporting at the end of its fifth month, now handles approximately 20,000 accounts per month (averaging collections of $31,000 a month), and has in its files 185,000 accounts.

There are three reasons why a similar bureau is a "must" in any city large enough to support one, says F. C. MacConnell, Jr., manager. "Prior to the existence of the Maricopa bureau, grievances filed with the medical society reached an alarming number due to harsh and tactless methods of commercial collection agencies," he explains. "In 1951 there were 72 grievances reported, most related to fees; in 1956 there were only 6. Further, our bureau provides for a thorough investigation of each case, a process vital to ethical handling. And, thirdly, if a debtor owes five different doctors, it is best for all concerned if the accounts are handled by one agency and monies received are divided properly."

In Mr. MacConnell's opinion, "There are obvious advantages in a society owned and operated bureau where the systems and procedures used are dictated by the doctors themselves as compared with a privately owned collection agency 'endorsed' by the medical society." In addition to avoiding the harsh commercial collection methods that have hurt their practice in some instances, members of a medical society that operates its own bureau benefit from a better control of grievances and malpractice suits, additional services that otherwise would have to be paid from society dues, and aid in the reduction of dues.

"Our policy in handling delinquent accounts is firm but courteous, keeping in mind at all times the public relations angle," Mr. MacConnell points out. "We are sympathetic if our investigation reveals a genuine hardship exists, but we exhibit a necessary degree of firmness if a person has the financial ability to pay and refuses to cooperate."

"From the public relations angle, which is best," Mr. MacConnell asks: "(1) to use maximum collection procedures if necessary to collect a fair and just bill, (2) to cut a bill in half and have the patient feel that he was overcharged in the beginning, or (3) to forget the whole thing and have the patient think that the doctor so grossly overcharged that he didn't have the nerve to try to collect?"

Individual Basis, Tarrant View

Fort Worth doctors are also informed on the advantages and disadvantages of credit bureaus.

Writes Dr. Emory Davenport, secretary of the Tarrant County Medical Society, "The society does not maintain any medical credit bureau. We did, some years ago, endorse a bureau known as the Doctors' Credit Bureau, which operates entirely independent of the society, and, in addition to this, the Retail Merchants Credit Bureau handles most of the individual doctor's business."

Those doctors—in Texas and elsewhere—who prefer to do without outside assistance in financial relations with their patients are as vehement about their opinions as are the physicians who feel credit bureaus are necessities.

The 47 doctors of 140 queried by Dr. DeTar, for example, say they write off from 25 to 100 per cent of their overdue accounts rather than forward them to an agency.

"I don't want to risk antagonizing my patients," says one.

"The agency's commission here—50 per cent—is far too high," say another. "How many patients realize that only half the money the agency collects from them is ever turned over to the doctor?"

Finally, asserts a Texas general practitioner, "I'm not at all sure that I *want* to know each new patient's credit rating the first time I treat him. If he comes into my office and needs my medical aid, I'm certainly going to give it to him, regardless!"

This, then, is the story of medical credit bureaus. It must remain with the individual doctor to decide whether, and to what extent, he uses one.

EDUCATION

Postgraduate Courses

Radiation for Industrial Physicians and Lawyers, Cincinnati, September 9-14.—Radiation, its language, and the fundamentals needed for the proper appreciation of health and legal problems will be explained the first two days to both groups. Then each group will hear separate lectures aimed at its respective field of interest. Tuition is $100; for further information write to the Secretary, Institute of Industrial Health, Kettering Laboratory, College of Medicine, University of Cincinnati 19.

Laboratory Refresher Training Courses, Chamblee, Ga., and Montgomery, Ala., September 9-March 28.—Twenty-two courses in laboratory methods will be offered during this period under the auspices of the Department of Health, Education, and Welfare Public Health Service, Communicable Disease Center. A list of the courses, information, and application blanks may be secured from the Laboratory Branch, Communicable Disease Center, U. S. Public Health Service, P. O. Box 185, Chamblee, Ga.

Occupational Medicine, New York, September 16-November 8.—Designed for physicians in industry, this course will cover preventive medicine, administrative medicine, occupational diseases, and industrial hygiene. The Office of the Associate Dean, New York University Post-Graduate Medical School, 550 First Avenue, New York 16, can supply additional information.

Ophthalmology for Specialists, New York, September 16-December 6.—These courses include:

Histopathology—Dr. A. Marvin Gillman will direct this part-time course September 16-20.

Surgery of the Eye—A full-time course under the direction of Dr. Rudolph Aebli will be given October 28-November 2.

Ophthalmoscopy—This will be a part-time course November 4-8 directed by Dr. George N. Wise.

Surgery of the Cornea—Dr. Ramon Castroviejo will direct this full-time course December 2-6.

Complete information about these courses may be obtained from the Office of the Associate Dean, New York University Post-Graduate Medical School, 550 First Avenue, New York 16.

What's New for the General Physician in Medicine, Pediatrics, Psychiatry, and Dermatology? New York, September 17-May 27.—This part-time interdepartmental course will consist of clinical presentations, demonstrations, lectures and panels, and special emphasis on current diagnostic procedures and advances in therapy. Tuition is $300; individual sessions may be attended on a pro rata basis. Information is available from the Office of the Associate Dean, New York University Post-Graduate Medical School, 550 First Avenue, New York 16.

Modern Concepts of the Etiology, Pathologic Physiology and Therapy of Diseases with Surgical Implications, New York, September 12-June 12.—This part-time course has been planned to interest general practitioners, surgeons, and internists. Tuition is $300, or on a pro rata basis for each session. For details write the Office of the Associate Dean, New York University Post-Graduate Medical School, 550 First Avenue, New York 16.

Occupational Skin Problems, Cincinnati, October 28-November 1.—Morning lectures and clinical demonstrations, afternoon field instruction, and evening panel discussions will acquaint the doctors with cutaneous problems of occupational origin. Application may be made to the Secretary, Institute of Industrial Health, Kettering Laboratory, Eden and Bethesda Avenues, Cincinnati 19. Attendance will be limited.

Pediatric Allergy, New York, November 6-May 28.—Applicants must be certified in pediatrics or have the requirements for certifications. A limited number of allergists practicing with adults may apply. Information is available from the Office of the Dean, New York Medical College, Fifth Avenue at 106th, New York 29.

Postgraduate Courses, 1957-1958, New York—Mount Sinai Hospital, in affiliation with Columbia University, offers a full selection of postgraduate courses both for general practitioners and specialists. General practice courses are in the fields of hematology, internal medicine, neurology, pathology, physiology, psychiatry, and radiology. Specialists may select courses in neurology, ophthalmology, otorhinolaryngology, radiology, or surgery. A description of these courses may be obtained by writing to the Registrar for Postgraduate Medical Instruction, Mount Sinai Hospital, Fifth Avenue and 100th Street, New York 29.

University of Texas Medical Branch

A psychiatric hospital of 150 beds is in the planning stage by the Sealy and Smith Foundation for the University of Texas Medical Branch Hospitals group in Galveston.

New School of Aviation Medicine

Ground was broken in May for the new $9,000,000 School of Aviation Medicine in San Antonio. Four units now are under construction—the research institute, academic building, flight medicine laboratory, and shops. Later, an altitude laboratory will be added. At the research institute will be the aeromedical library, experimental laboratories, and the offices of the commandant.

Classrooms accommodating 700 students, plus an auditorium seating 400 will be in the academic building, and tests of flying fitness will be developed and evaluated in the flight medicine laboratory. The shops will turn out instruments for research projects and will contain electronic equipment to analyze statistical data.

A closed-circuit television system, with a link to Lackland Air Force Base, will enable students in classrooms to watch the treatment of patients by flight surgeons at the Lackland hospital.

It is hoped that the new school will be occupied by July, 1959.

Houston VA Hospital Residency Offered

The Houston Veterans Administration Hospital offers a three year approved residency in physical medicine and rehabilitation, which is available in either the regular or career type appointment. The regular residency has a stipend range of $2,840-$3,550 per annum; the career type, with a staff-status salary, a range of $5,915-$8,990 per annum, with an obligation to serve the Veterans Administration for two years after three years' residency. Further information is available from Dr. Lewis A. Leavitt, chief of the physical medicine and rehabilitation service of the hospital.

MEDICOLEGAL NOTES

Liability of Partner

There is probably only little misunderstanding as to the possible liability of partners or associates in regard to a malpractice action, but it might be enlighting if the applicable principles and the reasons behind them were set forth.

As regards the liability of one partner for the negligent acts of another partner, which result in a malpractice action, there seems to be no doubt as to the liability of all of the partners, although there is a lack of cases dealing with this principle as it applies to physicians. The case that would probably be controlling as to this issue is Lee v. Moore.* (Although this case was reversed on appeal, it was reversed upon a point other than the one presented here.) In this case, the physician was sued for malpractice for the alleged injury to plaintiff's wife while confined in childbirth. Subsequent to the birth of plaintiff's child, the defendant physician agreed to care for the wife. Shortly before the birth of the child, it developed that the defendant physician was going to be unable to be present at the birth of the child. As a result, the defendant physician arranged with another physician to assist him in treating the patient. It is as a result of this action that the malpractice suit was brought.

One of the contentions which is mentioned in this case is whether the two physicians might be considered as partners, and if so, could the defendant physician be held liable for the negligent acts of the physician he had arranged to care for his patient. The court, in its opinion, stated that:

> Likewise, partners in the practice of medicine are all liable for an injury resulting from the negligence, either of omission or commission, of one of the partners within the scope of their partnership business. 30 C.Y.C. p. 1581. Whittaker v. Collins, 25 N.W. 632. The principle or theory upon which this holding is based is that partners in the practice of medicine are sureties for the faithful performance of their engagements by each of them. Hyrne v. Erwin, 23 S.C. 226.

This would seem clearly to set out the rule that one partner can be held liable for the negligent acts of another partner, even though he is not present or had no part in such negligent acts. Of course, this principle is qualified to the extent that the partner guilty of such negligent acts must have been acting within the scope of their partnership business. Even though this has the effect of somewhat limiting the liability of the partner or partners from all liability incurred by another partner, it would be most unlikely that it would exempt them from liability if the negligent partner was in any manner engaged in the treating of a patient or going about the partnership business at the time of the negligent acts.

The next question that arises is as to the liability of an associate, that is, one attending the same patient but not a partner. This question would seem to be readily answered by the case of Floyd v. Michie† in which the family physician was unwilling to diagnose or treat the patient and called in on various occasions two skin specialists. Both consulting physicians arrived at the same diagnosis and prescribed a course of treatment for the family physician to follow. Subsequent to this, the child being treated died, and from such result, a malpractice suit developed. The court, in this case, held upon the authority of Moore v. Lee‡ that

> A physician is not liable for the negligence of another independent practitioner whom he (in the exercise of reasonable care) recommends because he is unwilling to assume the responsibility of diagnosing and treating the malady and whose services are accepted and continued under an independent contract.

This holding seems to answer the question that was raised, but the position is further supported by the Supreme Court of Texas in Moore v. Lee‡ in which the court quoting 21 Ruling Case Law, pages 394-395, held that

> They may make such division of services as in their honest judgment the circumstances may require and each, in serving with the other, is rightly held answerable for his own conduct and as well as for all the wrongful acts or omissions of the other which he observes and lets go on without objection, or which in the exercise of reasonable diligence under the circumstances he should have observed. But beyond that his liability does not extend. Finally, it seems that a physician or surgeon may, on leaving town or in other case of need, recommend or employ another physician or surgeon to treat a patient for him, and in the absence of negligence in such selection, will not be liable for the negligence or lack of skill of the substitute practitioner.

From the reasoning of the last two cited cases, it would seem apparent that in the case of associates there would be no liability imputed to the other physician, unless such other physician observed, or should have observed, wrongful acts being performed and failed to object.

From a study of these cases, I believe it will be possible

*162 S.W. 437.

†11 S.W. (2d) 657.

‡211 S.W. 214.

to understand better the reasoning and the liability involved in cases concerning partners and associates. In the next issue of the *Journal*, I intend to discuss possible liability to the physician for the acts of others who are not physicians.

—PHILIP R. OVERTON, LL.B., Austin.

National Legislative Developments

The special draft legislation that has been used to call physicians and related professionals into military service for half a dozen years has expired, and the new doctor draft replacement bill (H.R. 6548) went into effect July 1. The priorities and special registration of physicians ceased to exist, although physicians, dentists, and allied specialists who are liable for induction under the regular draft program may be called into service because of their profession. The advisory committees to Selective Service; appointment of physicians to a rank commensurate with their training, experience, and ability; and utilization of doctors as enlisted men if they refuse or fail to qualify for commissions will be continued. Under the special draft act, 10,423 physicians and 4,224 dentists were supplied to the armed forces.

At about the time the draft measure was being completed, the administration's bill for contributory health insurance for federal civilian employees and their dependents—long under study—was introduced into Congress. The new bill provides both basic and major coverage, and a worker would have to take both coverages to get government contributions. For basic coverage the government would pay one-third of the premium up to 50 cents biweekly if the worker alone is insured or up to $1.50 biweekly if dependents are included. Each employee would be free to choose any locally available group plan meeting minimum standards set up in the law. The government contribution for major coverage would be one-third of the premium, 12.5 cents biweekly for the worker alone or 37.5 cents for the employee with dependents. The plan would pay 75 per cent of surgical and other medical costs in excess of $100. Benefits would be limited to a lifetime maximum of $10,000 and a calendar year maximum of $5,000 for the insured or retired worker and each covered dependent. Basic coverage could be continued by the employee after retirement but without government contribution; major coverage would be continued at no cost to the employee after he reached age 65 or upon retirement.

It was expected that H.R. 7238 and its companion bill in the Senate, S. 1209, amending the social security law to liberalize the formula of vendor payments for medical services given to persons receiving public assistance, would be enacted soon after approval by the House Ways and Means Committee early in June.

Meanwhile, Congress has terminated the civil defense programs paid for by funds allocated through the Federal Civil Defense Administration to the Department of Health, Education, and Welfare (and other departments) for use by state and local health departments, medical schools, and hospitals. The MEND program (Medical Education for National Defense), technical aid to hospitals and health facilities in such areas as research against biological and chemical warfare agents, and special training of epidemiologists and sanitary engineers in state and local health departments are examples of the programs that must be suspended. In sustaining the drastic reductions made by the House in FCDA funds, the Senate Appropriations Committee made it clear that the Department of Health, Education, and Welfare is not to continue any of the emergency civil defense programs with its own funds.

At the same time a new dollar record is being set for grants to universities, hospitals, and other institutions for medical research support. Although a compromise was necessary to resolve differences in House and Senate authorizations, it was anticipated that a quarter billion dollars would be allocated to the National Institutes of Health alone.

Various other bills relating to health and medicine, most of them similar to bills already pending, have been introduced in the past few months.

MEMORIAL LIBRARY

MEDICAL ECONOMICS BIBLIOGRAPHIES

I. Investments*

For generations it has been said there were four reasons why people save money:

1. Emergencies, such as temporary loss of earning capacity, sickness, or similar emergencies.
2. Disability, in case the principal income producer is unable to work.
3. Old age.
4. Death, to provide an income for their families.

These four hazards are not within the control of man; therefore, they can only be recognized and plans made to meet them. The physician cannot be compared with the business man, who builds up a successful business enterprise to pass on to his family. The physician builds up a lifetime of good will because of his ability to administer to the ill, but any one of the four hazards can wipe away his income. Therefore, he must plan ahead.

During the past few months the following articles have appeared in the medical literature. All references are to be found in the Memorial Library of the Texas Medical Association.

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Glassen, Clarence W.: More Family Income Through Mutual Funds, J. Kansas M. Soc. 56:676-678 (Dec.) 1955.

Guthrie, Robert C.: Your Bank's Trust Department in Estate Planning, J. Kansas M. Soc. 56:667-672 (Dec.) 1955.

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**This is the first of a series of four bibliographies on medical economics which will be published in the* Journal. *Topics will be investments, partnerships, insurance, and fees.*

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Owens, Thomas: Can You Pass This Business Quiz? Med. Econ. 34:145-149 (June) 1957.

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Rankin, George C.: U. S. Savings Bonds—A Good Investment, J. Kansas M. Soc. 56:679-682 (Dec.) 1955.

Robinson, G. Wilse, Jr.: Editorially Speaking, Bull. Tarrant Co. M. Soc. 29:10-11 (May) 1957.

Should You Switch Savings Bonds? Med. Econ. 34:358-359 (April) 1957.

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Stabler, C. Norman: Investing for the Successful Physician—Projects Growth of Mutual Funds, M. Times 85:99a-118a (March) 1957.

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Stokely, Robert W.: What the Doctor Should Know About Financial Planning, J. Am. M. Women's A. 10:347-349 (Oct.) 1955.

Swanberg, Harold: Retirement Income Benefits for Physicians, Mississippi Valley M. J. 79:163-164 (May) 1957.

Which Mutual Funds Grow Fastest? Med. Econ. 34:18-19 (Feb.) 1957.

Wormser, R. A.: Five Steps to Take Before You Make a Will, Med. Econ. 34:134-142 (March) 1957.

Wormser, R. A.: Nine Provisions Not to Include in Your Will, Med. Econ. 34:142-145 (May) 1957.

Wormser, R. A.: Planning Your Family's Financial Future: Ways to Leave Money to Your Heirs, Med. Econ. 34:212-220 (June) 1957.

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Following is a continuation of a list of recent articles published by Texas physicians and available at the Memorial Library of the Texas Medical Association. Articles appearing in the *Texas State Journal of Medicine* are not included.

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Simkin, Samuel: Proctological Problems in Pediatric Practice, M. Rec. & Ann. 50:176-178 (Aug.) 1956.

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Suehs, Oliver M.: Chronic Secretory Otitis Media: Etiology, Diagnosis and Treatment J.M.A. Georgia 45:499-506 (Dec.) 1956.

Tabler, James W.: Management of Rh-Sensitized Patient, Am. J. Obst. & Gynec. 72:959-962 (Nov.) 1956.

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Tevetoglu, Fethi: Pediatric Use of Dioctyl Sodium Sulfosuccinate, J. Pediat. 49:304-307 (March) 1957.

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Thompson, Ian M., and Lantin, Pedro M.: Parameatal Cysts of Glans Penis, J. Urol. 76:753-755 (Dec.) 1956.

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Dr. Henry L. Hilgartner, Austin, 16 journals; reprints.
Dr. J. O. S. Holt, Dallas, 1 tape recording.
Dr. James E. Kreisle, Austin, 1 book.
Dr. B. E. Pickett, Sr., Carrizo Springs, 8 journals.
Rugeley-Blasingame Clinic, Wharton, 311 journals.
Dr. Nelson L. Schiller, Austin, 17 journals; 42 reprints.
Dr. Claude A. Selby, Sinton, 519 journals.
Dr. Lorraine Stengl, El Campo, 39 journals; 51 reprints.
Dr. R. T. Wilson, Austin, 8 journals.

TAPE RECORDING

A Consultation Hour in Current Problems of Obstetrics and Gynecology

Symposium of the American College of Obstetricians and Gynecologists.

★ Motion Pictures

First a Physician

Color, sound, 27 minutes, 1956.

This film tells an interesting, dramatic story and at the same time reveals the daily contributions made by radiologists in the diagnostic and therapeutic application of radiant energy. It is suitable for showing to civic, school, and medical groups.

Mr. Finley's Feelings

Color, sound, animated, 10 minutes, 1957.

This film on emotional health shows how Tom Finley, during a day of stress, reacts to his boss, his family, his closest friend, and other important people in his life. One important sequence concerns the influence of emotions on an automobile driver's competence. A guide for the discussion leader is provided with each print. Audience discussion may focus on one or more of the following subjects: family life, employee-employer relations, teacher-student relations, traffic safety, and the individual's emotional health.

★ Books

BOOKS NEWLY ACQUIRED

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Vorhaus, Martin G.: *Changing Patient-Doctor Relationship*, New York, Horizon, 1957.

Williams, Marian, and Worthingham, Catherine: *Therapeutic Exercises*, W. B. Saunders, 1957.

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BOOK NOTES

Reflections on Renal Function

JAMES R. ROBINSON, M. D., Ph. D. (Cantab.), *Assistant Director of Research, Department of Experimental Medicine, Medical Research Council and University of Cambridge, Fellow and Assistant Tutor of Emmanuel College. 163 pages. $3.50. Springfield, Ill., Charles C Thomas, 1954.*

This eight chapter book derived from lecture notes of the author at Cambridge University fills the need for a short summary of the physiology of the kidney. It is filled with good information, but it must be read with concentration, as a book on this subject cannot be read as a novel. The author covers glomerular and tubular function, excretion of sodium and water, acid-base balance, control of renal function, and regulation of fluid volume in moderate detail and readable style.

It can be recommended to all interested in renal physiology.

—R. K. Arnett, M. D., Lufkin.

Subacute Bacterial Endocarditis

ANDREW KERR, JR., M. D., *Assistant Professor of Medicine, Louisiana State University School of Medicine, New Orleans. 343 pages. $6.50. Springfield, Ill., Charles C Thomas, 1955.*

In his introduction, the author proposes that two years of antibiotic therapy offer "a propitious time to document our information about subacute bacterial endocarditis." The text is extremely concise and well organized and will prove an outstanding source of reference until the rapidly moving field of antibiotics requires another summation. Any practitioner having a problem case or wishing to prepare a paper on some aspect of bacterial endocarditis will find this monograph an ideal starting point.

The author has presented his material in a very factual manner. Perhaps there is less personal opinion expressed than some may wish, and there are virtually no graphs or charts. The reader will readily come upon the references to original articles which he will want to pursue further in his study of the subject.

Dr. Kerr is to be complimented on a task well done.

—E. Ross Kyger, Jr., Fort Worth.

Pelvimetry

HERBERT THOMS, M. D., *Emeritus Professor of Obstetrics and Gynecology, Yale University School of Medicine, New Haven. 120 pages. $5. New York, Harper and Brothers, 1956.*

This brief monograph by a leading authority is of primary interest to obstetrical specialists for reason of the space devoted to developmental anatomy and pathological variations of the female pelvis. The readibility of the text is considerably reduced by Dr. Thoms' terminology, which is not widely used in this part of the country. However, his clinical points are well taken and the description of his "grid-method" roentgenometry is concise and complete. The concluding chapter, "A Single Film Screening Survey," presents a method of practical importance to every doctor doing obstetrics.

Obviously this publication was not written as a reference book on x-ray pelvimetry, but as a presentation of the author's own conclusions from a wide clinical experience and his well-founded plea for increased use of roentgenometry in obstetrics.

—W. S. Parks, Jr., M. D., Midland.

Wire Brush Surgery, in the Treatment of Certain Cosmetic Defects and Diseases of the Skin

JAMES W. BURKS, JR., M. S., M. D., *Associate Professor of Clinical Medicine, Tulane University of Louisiana School of Medicine. 154 pages. $6.75. Springfield, Ill., Charles C Thomas, 1956.*

This book contains a complete summary of the known published as well as the author's personal experience in 750 skin planings. The 12 chapters cover all of the indications and contraindications of wire brush surgery. The anatomy and histopathology as well as the psychological aspects of this subject are discussed fully. Even for those who never have held an abrasive instrument in their hands, the procedure appears simple after reading this book. There are 68 illustrations that completely tell the story of wire brush surgery. Most of the pictures are multiple. This book serves a useful purpose for all dermatologists and other physicians who wish to undertake wire brush surgery.

—D. O. Poth, M. D., San Antonio.

Fractures, Dislocations and Sprains

JOHN ALBERT KEY, M. D., F.A.C.S., *St. Louis, Clinical Professor Emeritus of Orthopedic Surgery, Washington University School of Medicine; and* H. EARLE CONWELL, M. D., F.A.C.S., *Birmingham, Associate Professor of Orthopaedic Surgery, University of Alabama School of Medicine. ed. 6. 1168 pages. $20. St. Louis, C. V. Mosby, 1956.*

The reviewer has always regarded this book as the outstanding fracture book written in any language. His reason is that this particular book is comprehensive but above all it is practical. Most other books on fractures stress one particular type of treatment over another and tend to include radical methods that are not standard. This book includes only tried and true methods and stresses the simple methods over the most complex ones. In many of the more common fractures and most of the complicated fractures, more than one method is described so that a reader will have available a good comprehensive approach to the problem under discussion. The constantly changing approaches to any problems in fracture treatment have been thoroughly covered. The newer methods of treatment have been included and obsolete ones deleted. The illustrations are excellent. Each subject is presented concisely and without unnecessarily long narration.

—Louis W. Breck, M. D., El Paso.

Home Health Emergencies; A Guide to Home Nursing and First Aid in Family Health Emergencies

Bureau of Public Health, Medical Department, Equitable Life Assurance Society. 256 pages. New York, Equitable Life Assurance Society of the United States, 1956.

Dermatology

DONALD M. PILLSBURY, D.Sc. (Hon.), M.D., *Professor and Director of Department of Dermatology, University of Pennsylvania School of Medicine;* WALTER B. SHELLEY, M.D., Ph.D., *Associate Professor of Dermatology, University of Pennsylvania School of Medicine; and* ALBERT M. KLIGMAN, M.D., Ph.D., *Associate Professor of Dermatology, University of Pennsylvania School of Medicine. 1331 pages. $20. Philadelphia, W. B. Saunders Company, 1956.*

For the practicing physician, particularly one untrained in dermatology, this text at desk side would serve as a useful tool every day in practice. The nonspecialist is afforded a greater opportunity to understand the significance of certain eruptions since the authors have made an unusual effort to explain the patho-physiology in those conditions where it is understood.

By the use of a series of rather ingenious charts, the relationship of various factors, intrinsic and extrinsic, to some of the common dermatoses has been clearly represented. The omission of detailed histopathologic descriptions enhances the appeal of this text to the reader who does not confine his practice to dermatology, and by this omission more space is available for descriptive and illustrative material.

In a commendable attempt to minimize the confusing terminology associated with dermatological entities the authors have simplified the grouping of the various skin diseases but have maintained a thorough coverage of recognized dermatoses. Excellent photography and clear reproduction of these photographs add immeasurably to the text's value.

To select outstanding features of a uniformly good book is difficult, but mention should be made of the initial chapters on anatomy and physiology, which are unusually thorough. The concise summaries at chapter ends are outstanding in being unique as well as in organizing material clearly.

In a final recommendation of this book, it should be stated that it combines into one text dermatologic knowledge, both complete and accurate, written in a style featuring clarity and simplicity.

—H. D. Garrett, M.D., El Paso.

Clinical Selections in Dermatology and Mycology

FREDERICK REHM SCHMIDT, A.B., M.D., *Associate Professor of Dermatology, Northwestern University Medical School, Chicago, with contributions by Thirty-Six Specialists from Various Lands. 505 pages. $10.50. Springfield, Ill., Charles C Thomas, 1956.*

This book is composed of the writings of Dr. Schmidt and 36 collaborators, each of whom is well known in the field of dermatology or mycology and most of whom are from one of the countries of North or South America. Dr. V. Pardo-Castello, associate professor of dermatology and syphilology, University of Havana Medical School, contributes a chapter on "Eczematous Dermatitis;" Dr. Miguel Mazzini, associate professor, Department of Dermatology and Syphilology, Faculty of Medical Science, Buenos Aires, contributes a chapter on "Treatment of Syphilis." Among the collaborators from the United States are the following: Dr. J. Walter Wilson, associate professor, Department of Dermatology, School of Medicine, University of Southern California, writing on "Comparative Pathogenisis of the Deep Mycosis," and Dr. S. William Becker, clinical professor, Department of Dermatology, University of Chicago, contributing a chapter on "Pigmented Nevi and Melanoma."

Dr. Schmidt, associate professor of dermatology, Northwestern University Medical School, practices in San Jose, Costa Rica. He has authored 14 of the book's 43 chapters; his selections range from such controversial subjects as "Vasospasm and Skin Disease" to a hodge-podge chapter entitled "A Pyodermic Synthesis." It would seem that the book was edited to give a place for the author to present his many controversial ideas on various obscure dermatologic disorders.

The greatest value of the book is to be found in the work of the collaborators, especially those from Mexico and South America. These writers have given concise descriptions of various diseases, especially the deep mycoses, and have added many pertinent and original observations of their own. These writers clearly show the great contributions our Latin American colleagues have made to medical science and especially to dermatology and mycology.

The book has no illustrations, but the type is large and the printing excellent. There are adequate references at the end of each chapter, and the volume is well indexed. The book is recommended to dermatologists if for no other reason than the one the author has pointed out in his preface, "Controversial opinions and original ideas are purposely emphasized in order to promote discussions leading to a better understanding of dermatologic problems."

—William C. King, M.D., Austin.

Anatomy for Surgeons: Vol. 2; The Thorax, Abdomen, and Pelvis

W. HENRY HOLLINSHEAD, Ph.D., *Professor of Anatomy, Mayo Foundation, University of Minnesota, Rochester. 934 pages. $12. New York, Harper & Brothers, Paul B. Hoeber, Inc., 1956.*

Dr. Hollinshead presents in readable form the regional anatomy which is of particular importance to the surgeon. He strived for two goals: to present to the younger surgeon a broad basic anatomy together with those details upon which the more mature surgeorn bases his daily work, and to provide for the more mature surgeon a refresher course for his own immediate field and those details slightly outside.

Each chapter has been reviewed and criticized by one or more surgeons or specialists particularly interested in the subject of the chapter.

The book is divided into three volumes "The Head and Neck"; "The Thorax, Abdomen, and Pelvis"; and "The Back and Limbs" so that surgeons interested in a particular field need keep only the pertinent volume on his reference shelf.

Techniques and Procedures of Anesthesia

JOHN ADRIANI, M. D., *Professor of Surgery, School of Medicine, Tulane University of Louisiana, and Clinical Professor of Surgery and Pharmacology, School of Medicine, Louisiana State University, New Orleans. ed. 2. 568 pages. $8.75. Springfield, Ill., Charles C Thomas, 1956.*

This edition is an addition to and revision of the first edition published in 1947. The author uses the same outline form in which he "enumerates the technical details of anesthesia and gives the associated reasons for executing them in the manner described."

The author discusses types of anesthesia, selection of anesthesia, examination of the patient, and preanesthetic

medication. The use of chlorpromazine for premedication was not mentioned.

Trichlorethylene was added to the list of inhalation agents. Muscle relaxants were given more discussion than before in the chapter on intravascular drugs. The chapters on complications, rectal anesthesia, regional anesthesia, resuscitation, and inhalation therapy remain much the same.

The significant addition is the discussion of specialized procedures. This includes the problems concerning both pediatric and geriatric anesthesia. Cardiac surgery has necessitated the use of hypothermia, and the techniques and complications arising from too rapid cooling and rewarming are mentioned. Thoracic surgery and obstetric analgesia and anesthesia also receive attention. Intentional hypotension, controlled respiration, and the use of mechanical respirators, are also discussed. The section on postanesthetic recovery room is important, and suggestions concerning construction, arrangement, beds, equipment, drugs, and personnel are thorough.

The book is well organized and its outline form provides important information which is readily accessible.

—D. L. Hunter, M. D., San Angelo.

The Neuroses in Clinical Practice

HENRY P. LAUGHLIN, M. D., *Assistant Clinical Professor of Psychiatry, George Washington University School of Medicine. 802 pages. Philadelphia, W. B. Saunders, 1956.*

This 14 chapter book is well written, practical, and can be read easily by specialist and general practitioner alike. The first two chapters contain an excellent discussion of the origin, nature, and types of anxiety reactions. The author's "mechanisms of defense" or mental mechanisms are somewhat elaborate. The author then goes into detail defining, describing, giving dynamics and treatment of the various neurotic reactions. In so doing, he makes liberal use of case illustrations.

The book ends with a brief summary of the neuroses following trauma. There follows a glossary of psychiatric concepts and terms.

Being a believer in "grass roots" psychiatry, I recommend the book to one and all.

—Albert D. Pattillo, M. D., Austin.

The Happy Life of a Doctor

ROGER I. LEE, M. D. *278 pages. $4. Boston, Little, Brown and Company, 1956.*

Witty, modest, and warmly personal, this book is an affectionate yet unvarnished glance at the medical life as one man has known and loved it through a wide span of years.

Vivid memories come to life: of the men of the Harvard Medical Unit, with which Dr. Lee made the trip overseas before America entered World War I; of the Massachusetts General Hospital at the time the x-ray machine was first hopefully set up in the room back of the apothecary shop; of work for the National Research Council in World War II—with one proud result being in the abolition of K. P. as punishment in the Army. There are glimpses of such great men of medicine as William Osler and Sir Alexander Fleming, discoverer of penicillin, and of great men of Harvard from the time of President Eliot to that of President Pusey. And there are such diverse personalities as John Singer Sargent, Walt Disney, and Winston Churchill, caught in a revealing moment before a famous speech.

Medical folk and laymen alike will find this story fascinating reading.

Poliomyelitis

W. RITCHIE RUSSELL, C.B.E., M.D., (Edin.), D.Sc. (Oxon.), F.R.C.P. (Edin.), F.R.C.P. (Lond.), *Director, Department of Neurology, United Oxford Hospitals; Clinical Lecturer in Neurology, University of Oxford. ed. 2. 147 pages. $3. London, Edward Arnold (Publishers) Ltd., 1956.*

Sleep

MARIE CARMICHAEL STOPES, D.Sc., Ph.D. *154 pages. $3. New York, Philosophical Library, 1956.*

J.A.M.A. Queries and Minor Notes

Published for the American Medical Association. 334 pages. St. Louis, C. V. Mosby Company, 1956.

A Psychiatric Glossary

COMMITTEE ON PUBLIC INFORMATION, AMERICAN PSYCHIATRIC ASSOCIATION. *48 pages. Washington, D. C., American Psychiatric Association, 1957.*

The American Fluoridation Experiment

F. B. EXNER, M. D., *and* G. L. WALDBOTT, M. D., *edited by James Rorty. 277 pages. $3.75. New York, Devin-Adair Company, 1957.*

★ American Medical Association

Texas Doctors Participate In AMA Business Sessions

The American Medical Association's House of Delegates had a busy session at the June meeting in New York, and Texas doctors were active in the proceedings.

Dr. B. E. Pickett, Sr., Carrizo Springs, chairman of the Council on Constitution and Bylaws, presented his report, which included an amendment to the Constitution, the proposed revision of the principles of medical ethics, and several proposed changes in the Constitution. The proposed principles of medical ethics are printed in toto in this *Journal.*

Texans made a fine showing in the scientific exhibit. In the Section on Orthopedic Surgery, a certificate of merit went to Dr. E. J. Tucker, Houston, and others, for an exhibit on Cultured Calf Bone Grafts. Dr. R. A. Murray, Temple, received honorable mention for his showing on Pollicization of the Index Finger. In the Section on Radiology, Drs. Vincent P. Collins, P. Gibbs, and I. David, Houston, received a certificate of merit for their exhibit, "How Does Cancer Grow?—Pulmonary Metastases."

The Texas delegation presented three resolutions which were approved by the House of Delegates; they concerned support of the Jenkins-Keogh bills, support of the Bricker amendment, and commendation of the television program.

"Dr. Hudson's Secret Journal." No action was taken on a Texas resolution regarding changes in blood banking procedures, but a similar resolution presented by a California delegate was accepted. It advocated full support of the Joint Blood Council, Inc., as the contracting agency for blood procurement with all governmental agencies. No action was taken on a resolution favoring repeal of the income tax law because the legislation in question does not deal with a matter of primary medical concern.

Three resolutions by Texas delegates were not approved. In considering a resolution opposing federal subsidy of medical education, the Reference Committee on Legislation and Public Relations recommended that it not be adopted, and that the House reaffirm its previous position of support for one-time matching federal grants for construction; the House adopted the reference committee's report. Likewise, a Texas resolution that the AMA should obtain membership approval prior to engaging in any medical service program of national impact was disapproved, as was a resolution supporting the proposed twenty-third amendment to the United States Constitution (barring the government from engaging in business, commercial, professional, or industrial enterprise in competition with private citizens).

Dr. John K. Glen, Houston, presented a resolution commending the annual essay contest sponsored by the Association of American Physicians and Surgeons. This was amended to express approval in principle of essay contests, and was adopted.

An important action was the adoption of a guide for relations with the United Mine Workers of America. This statement sets forth general rules about the responsibilities of the medical profession with third parties, specifically the UMWA welfare and retirement fund.

The House adopted a resolution condemning any payments under the Medicare program "to or on behalf of any resident, fellow, intern, or other house officer in similar status who is participating in a training program." Also adopted was a statement intended to provide assistance in attaining medical education of ever higher standards and to serve as a general criterion in the medical school accreditation program.

Two resolutions favoring compulsory inclusion of physicians in the federal social security system, and one calling for a nationwide referendum of AMA members on the issue were rejected.

Miscellaneous actions included recommendation of further study and a program of action to curb narcotic addiction; urging of a more careful screening of radio and television patent medicine advertisements; a directive to the Board of Trustees to investigate indiscriminate use of stimulants; opposition to the establishment of any further veterans facilities for the care of nonservice connected illnesses; opposition to the compulsory assessment of medical men and staff members by hospitals in fund raising campaigns; and recommendation that transportation expenses for section secretaries be paid for AMA meetings which they are required to attend.

Dr. David B. Allman, Atlantic City, was inaugurated as President, and Dr. Gunnar Gunderson, LaCrosse, Wis., was chosen President-Elect. The 1957 Distinguished Service Award of the AMA went to Dr. Tom D. Spies, head of the Department of Nutrition and Metabolism at Northwestern University Medical School, Chicago, for his contributions to the science of nutrition. Born in Ravenna, he is a native Texan. For only the third time in history, the House of Delegates voted a special citation to a layman for outstanding service in advancing the ideals of medicine and contributing to public welfare. Recipient of this award was Henry Viscardi, Jr., West Hempstead, N. Y., founder and president of Abilities, Inc., which employs only severely disabled persons.

The Texas Hospitality Room was a popular gathering place; 510 packs of "Tall Texan" cigarettes were handed out, and each day, 22 dozen yellow roses were flown from Tyler for the Hospitality Room. Continuous background music was furnished.

New Principles of Medical Ethics

These new principles of medical ethics, adopted by the American Medical Association at its most recent meeting, are intended to aid physicians individually and collectively in maintaining a high level of ethical conduct. They are not laws but standards by which a physician may determine the propriety of his conduct in his relationship with patients, with colleagues, with members of allied professions, and with the public.

Section 1—The principal objective of the medical profession is to render service to humanity with full respect for the dignity of man. Physicians should merit the confidence of patients entrusted to their care, rendering to each a full measure of service and devotion.

Section 2—Physicians should strive continually to improve medical knowledge and skill, and should make available to their patients and colleagues the benefits of their professional attainments.

Section 3—A physician should practice a method of healing founded on a scientific basis; and he should not voluntarily associate professionally with anyone who violates this principle.

Section 4—The medical profession should safeguard the public and itself against physicians deficient in moral character or professional competence. Physicians should observe all laws, uphold the dignity and honor of the profession and accept its self-imposed disciplines. They should expose, without hesitation, illegal or unethical conduct of fellow members of the profession.

Section 5—A physician may choose whom he will serve. In an emergency, however, he should render service to the best of his ability. Having undertaken the care of a patient, he may not neglect him; and unless he has been discharged he may discontinue his services only after giving adequate notice. He should not solicit patients.

Section 6—A physician should not dispose of his services under terms or conditions which tend to interfere with or impair the free and complete exercise of his medical judgment and skill or tend to cause a deterioration of the quality of medical care.

Section 7—In the practice of medicine a physician should limit the source of his professional income to medical services actually rendered by him, or under his supervision, to his patients. His fee should be commensurate with the services rendered and the patient's ability to pay. He should neither pay nor receive a commission for referral of patients. Drugs, remedies, or appliances may be dispensed or supplied by the physician provided it is in the best interests of the patient.

Section 8—A physician should seek consultation upon request; in doubtful or difficult cases; or whenever it appears that the quality of medical service may be enhanced thereby.

Section 9—A physician may not reveal the confidences entrusted to him in the course of medical attendance, or the deficiencies he may observe in the character of patients, unless he is required to do so by law or unless it becomes necessary in order to protect the welfare of the individual or of the community.

Section 10—The honored ideals of the medical profession imply that the responsibilities of the physician extend not only to the individual, but also to society where these responsibilities deserve his interest and participation in activities which have the purpose of improving both the health and the well-being of the individual and the community.

Executive Council, PR Conference, Indoctrination Program

Councils and committees of the Texas Medical Association will meet in Austin at the headquarters building September 6 and 7, and the Executive Council will convene Sunday, September 8.

The week end activities also will include a Public Relations Conference and Indoctrination Program on Saturday. Guest speakers at the conference will be Dan J. Forrestal, St. Louis, who is with the Monsanto Chemical Company and president of the Public Relations Society of America; Leo E. Brown, Chicago, director of the Department of Public Relations of the American Medical Association; and Melvin Munn, Dallas, director of public relations for Blue Cross—Blue Shield of Texas. Mr. Forrestal's topic will be "What Impression Do We Make?" and "The Bell Tolls" is the title of Mr. Brown's talk. Mr. Munn will discuss "Something for the Folks."

Two panel discussions will be held as part of the conference; the morning panel will be "Basic Public Relations Projects Which Every County Society Should Undertake" and the afternoon panel will be "What's New in County Public Relations?"

The Indoctrination Program, designed primarily for new members of the Association, will include talks to acquaint the audience with different aspects of organized medicine and with the various services of the Association.

OFFICERS, COUNCILS, AND COMMITTEES

Following are the officers, councils, and committees of the Texas Medical Association for the year 1957-1958 with the year in which their terms of office expire indicated in parentheses.

Officers

Denton Kerr, Houston, President.
Howard O. Smith, Marlin, President-Elect.
David W. Carter, Jr., Dallas, Vice-President.
J. M. Travis, Jacksonville, Secretary (1959).
C. Lincoln Williston, Austin, Executive Secretary.
T. H. Thomason, Fort Worth, Treasurer (1959).
Charles P. Hardwicke, Austin, Speaker of the House of Delegates.
James D. Murphy, Fort Worth, Vice-Speaker of the House of Delegates.

Board of Trustees

R. W. Kimbro, Cleburne, Chairman (1962).
G. V. Brindley, Temple, Vice-Chairman (1960).
J. B. Copeland, San Antonio, Secretary (1961).
Troy A. Shafer, Harlingen (1959).
Byron P. York, Houston (1958).

Board of Councilors

First District: C. E. Oswalt, Jr., Fort Stockton, Vice-Chairman (1958); Russell Holt, El Paso, Vice-Councilor.
Second District: Henrie E. Mast, Midland (1960).
Third District: Robert A. Neblett, Canyon (1959); William J. Campbell, Amarillo, Vice-Councilor.
Fourth District: O. H. Chandler, Ballinger (1958); James P. Anderson, Brady, Vice-Councilor.
Fifth District: Robert F. Gossett, San Antonio (1959).
Sixth District: F. W. Yeager, Corpus Christi, Chairman (1959); S. W. Bohmfalk, Weslaco, Vice-Councilor.
Seventh District: David Wade, Austin (1960); Ray L. Shepperd, Burnet, Vice-Councilor.
Eighth District: Carlos E. Fuste, Jr., Alvin (1960).
Ninth District: Herbert H. Duke, Baytown (1960); James H. Sammons, Highlands, Vice-Councilor.
Tenth District: Stephen B. Tucker, Nacogdoches (1960); Gail Medford, Lufkin, Vice-Councilor.
Eleventh District: C. E. Willingham, Tyler (1958); R. H. Bell, Palestine, Vice-Councilor.
Twelfth District: [1]Tom M. Oliver, Waco, Councilor (1959).
Thirteenth District: Travis Smith, Abilene (1958); W. P. Higgins, Jr., Fort Worth, Vice-Councilor.
Fourteenth District: R. M. Tenery, Waxahachie, Secretary (1958); B. E. Park, Dallas, Vice-Councilor.
Fifteenth District: H. O. Padgett, Marshall (1959); James E. Ball, Mt. Pleasant, Vice-Councilor.

Delegates to the American Medical Association and Alternates

T. C. Terrell, Fort Worth (1959).
Alternate: G. W. Cleveland, Austin (1959).
M. O. Rouse, Dallas, Chairman (1959).
Alternate: J. W. Rainer, Odessa (1959).
J. B. Copeland, San Antonio (1959).
Alternate: George Turner, El Paso (1959).
Troy A. Shafer, Harlingen (1958).
Alternate: John L. Otto, Galveston (1958).
John K. Glen, Houston (1958).
Alternate: Robert W. Kimbro, Cleburne (1958).
L. C. Heare, Port Arthur (1958).
Alternate: [2]Ridings E. Lee, Dallas (1958).
James H. Wooten, Columbus (1958).
Alternate: L. H. Reeves, Fort Worth (1958).
Delegate Designate: J. C. Terrell, Stephenville.
Alternate Delegate Designate: J. L. Cochran, San Antonio.

Executive Council

Ex officio, President (Chairman), President-Elect, Vice-President, Secretary, Executive Secretary, Treasurer, Speaker of the House of Delegates, Vice-Speaker of the House of Delegates, Board of Trustees, Board of Councilors, Texas Delegates to the American Medical Association, Chairmen of all Councils, Members of the Council on Medical Jurisprudence, and Chairman of the Committee on Public Relations.

Council on Medical Defense

Charles L. McGehee, San Antonio, Chairman (1960).
P. M. Kuykendall, Ranger (1962).
Louis W. Breck, El Paso (1961).
John H. Wootters, Houston (1959).
W. P. Philips, Greenville (1958).
Denton Kerr, Houston (ex officio).
C. Lincoln Williston, Austin (ex officio).

Council on Medical Jurisprudence

G. W. Cleveland, Austin, Chairman (1959).
John M. Smith, Jr., San Antonio (1962).
Robert D. Moreton, Fort Worth (1961).
Mylie E. Durham, Jr., Houston (1960).
J. W. Rainer, Odessa (1958).
Denton Kerr, Houston (ex officio).
C. Lincoln Williston, Austin (ex officio).

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[1]*Appointed May 14, 1957, to succeed Dr. Howard O. Smith, Marlin, who resigned upon his election as President-Elect.*

[2]*Appointed April 10, 1957, to succeed Dr. Raleigh R. Curtis, Temple, who resigned April 10, 1957.*

COUNCIL ON SCIENTIFIC WORK

L. Bonham Jones, San Antonio, Chairman (1961).
Herman C. Sehested, Fort Worth (1962).
E. D. McKay, Amarillo (1960).
John C. Kennedy, Houston (1959).
B. H. Williams, Temple (1958).
Denton Kerr, Houston (ex officio).
C. Lincoln Williston, Austin (ex officio).

COUNCIL ON MEDICAL ECONOMICS

Harvey Renger, Hallettsville, Chairman (1962).
A. G. Barsh, Lubbock (1961).
C. F. Jorns, Houston (1960).
Gail Medford, Lufkin (1959).
Charles D. Bussey, Dallas (1958).
Denton Kerr, Houston (ex officio).
C. Lincoln Williston, Austin (ex officio).

COUNCIL ON MEDICAL EDUCATION AND HOSPITALS

Albert W. Hartman, Jr., San Antonio, Chairman (1962).
Truman G. Blocker, Jr., Galveston (1961).
[3]Olin B. Gober, Temple (1960).
William V. Leary, Houston (1959).
John S. Chapman, Dallas (1958).
Denton Kerr, Houston (ex officio).
C. Lincoln Williston, Austin (ex officio).

COUNCIL ON CONSTITUTION AND BY-LAWS

John F. Thomas, Austin, Chairman (1960).
Ridings E. Lee, Dallas (1962).
R. H. Bell, Palestine (1961).
J. Charles Dickson, Houston (1959).
David T. McMahon, Jr., San Antonio (1958).
Charles P. Hardwicke, Austin (ex officio).
James D. Murphy, Fort Worth (ex officio).
Denton Kerr, Houston (ex officio).
C. Lincoln Williston, Austin (ex officio).

WAR COUNCIL

Ex officio, President (Chairman), President-Elect, Vice-President, Secretary, Executive Secretary, Treasurer, Speaker of the House of Delegates, Board of Trustees, Board of Councilors, Chairmen of all Councils, and Chairman of the Committee on Public Relations.

COMMITTEE ON CANCER

Porter Brown, Fort Worth, Chairman (1958).
E. T. Driscoll, Midland (1962).
J. L. Goforth, Dallas (1962).
David H. Allen, Wichita Falls (1961).
Richard G. Granbery, Marshall (1961).
R. Lee Clark, Jr., Houston (1960).
Samuel J. Merrill, Brownsville (1960).
Charles Phillips, Houston (1959).
John D. Weaver, Austin (1959).
Jack G. S. Maxfield, Dallas (1958).

COMMITTEE ON MEDICAL HISTORY

[4]William M. Crawford, Fort Worth, Chairman (1962).
L. H. Reeves, Fort Worth (1961).
Truman C. Terrell, Fort Worth (1960).
[5]W. D. Thames, Jr., Lufkin (1959).
Tate Miller, Dallas (1958).

[3]*Appointed April 3, 1957, to succeed Dr. Delphin von Briesen, El Paso, who resigned.*

[4]*Appointed chairman upon the resignation of Dr. Tate Miller, Dallas, as chairman.*

[5]*Appointed July 3, 1957, to replace Dr. Felix P. Miller, El Paso, who died August 23, 1956.*

COMMITTEE ON PUBLIC RELATIONS

Joe R. Donaldson, Pampa, Chairman (1961).
A. F. Clark, Jr., San Antonio (1962).
Thomas Royce, Houston (1960).
Van D. Goodall, Clifton (1959).
Vacancy (1959).
Glenn D. Carlson, Dallas (1958).
[6]Vacancy (1958).

COMMITTEE ON TUBERCULOSIS

W. D. Anderson, San Angelo, Chairman (1961).
J. Walter Park, III, San Antonio (1962).
John A. Wiggins, Fort Worth (1962).
Porter Bailes, Tyler (1961).
[7]Vacancy (1960).
Dan E. Jenkins, Houston (1960).
John W. Middleton, Galveston (1959).
John W. Overstreet, Houston (1959).
Elliott Mendenhall, Dallas (1958).
R. B. Morrison, Austin (1958).

COMMITTEE ON MENTAL HEALTH

Hamilton Ford, Galveston, Chairman (1958).
A. D. Pattillo, Austin (1962).
Dorothy Wyvell, Midland (1962).
W. S. Barcus, Fort Worth (1961).
Robert L. Johnson, Pittsburg (1961).
David M. Keedy, San Antonio (1960).
[8]Holland C. Mitchell, Waco (1960).
Frank S. Schoonover, Fort Worth (1959).
Andrew S. Tomb, Victoria (1959).
P. C. Talkington, Dallas (1958).

COMMITTEE ON PUBLIC HEALTH

Elias Strauss, Dallas, Chairman (1959).
Austin Hill, Houston (1962).
James E. Ball, Mt. Pleasant (1962).
Thomas P. Kennerly, Houston (1961).
Ben Primer, Sr., Austin (1961).
Thomas H. Diseker, San Antonio (1960).
H. K. Brask, San Angelo (1960).
Henry A. Holle, Austin (1959).
T. A. Fears, Beaumont (1958).
William E. Lockhart, Jr., Alpine (1958).

COMMITTEE ON BLOOD BANKS

E. E. Muirhead, Dallas, Chairman (1961).
O. J. Wollenman, Jr., Fort Worth (1962).
K. P. Wittstruck, Waco (1960).
D. A. Todd, San Antonio (1959).
W. J. Emerson, Laredo (1958).

COMMITTEE ON INDUSTRIAL HEALTH

Val C. Baird, Houston, Chairman (1959).
S. W. Bradford, Tyler (1962).
N. B. Daniel, Texarkana (1962).
G. B. Stephenson, Beaumont (1961).
R. H. Thomason, Corpus Christi (1961).
Robert J. Potts, Dallas (1960).
Max E. Johnson, San Antonio (1960).
V. M. Payne, Jr., Dallas (1959).
Ralph G. Greenlee, Midland (1958).
Carl A. Nau, Galveston (1958).

[6]*Created by the resignation of Dr. Raleigh R. Curtis, Temple, April 27, 1957.*

[7]*Created by the resignation of Dr. Ralph E. Gray, Lake Jackson, in July, 1956.*

[8]*Appointed May 14, 1957, to succeed Dr. Hardy A. Kemp, Houston, resigned.*

COMMITTEE ON PATIENT CARE

Joseph F. McVeigh, Fort Worth, Chairman (1961).
G. V. Brindley, Jr., Temple (1962).
[9]Vacancy (1960).
G. E. Brereton, Dallas (1959).
Russell D. Holt, Jr., Meridian (1958).

COMMITTEE ON NATIONAL EMERGENCY MEDICAL SERVICE

Ralph E. Gray, Lake Jackson, Chairman (1961).
Ralph A. Munslow, San Antonio (1962).
T. E. Dodd, Austin (1960).
W. H. Hamrick, Houston (1959).
J. M. Hill, Dallas (1958).

COMMITTEE FOR LIAISON WITH WORKMEN'S COMPENSATION INSURANCE COMPANIES

Sam N. Key, Jr., Austin, Chairman (1961).
Edward T. Smith, Houston (1962).
Frederick C. Rehfeldt, Fort Worth (1960).
M. H. Morris, San Antonio (1959).
R. G. Carpenter, Dallas (1958).

[10]COMMITTEE ON SCIENTIFIC EXHIBITS

J. Edward Johnson, Austin, Chairman (1960).
J. E. Miller, Dallas (1962).
May Owen, Fort Worth (1962).
W. S. Fields, Houston (1961).
Jack M. Partain, San Antonio (1961).
Dennis Voulgaris, Wharton (1960).
R. R. White, Temple (1959).
Jasper H. Arnold, Houston (1959).
David Greer, Jr., Houston (1958).
Herbert H. Harris, Houston (1958).

[10]COMMITTEE ON SCHOOL-PHYSICIAN RELATIONS

Jay J. Johns, Taylor, Chairman (1962).
R. K. Arnett, Lufkin (1962).
E. E. Addy, Jr., Cisco (1961).
A. R. Hazzard, Giddings (1961).
M. T. Braswell, Henderson (1960).
Paul H. Mitchell, Corsicana (1960).
E. L. Hunt, Lubbock (1959).
L. H. Leberman, Commerce (1959).
J. Collier Rucker, Jacksonville (1958).
E. E. Lowrey, Gatesville (1958).

[10]COMMITTEE ON RURAL HEALTH AND DOCTOR DISTRIBUTION

Chester U. Callan, Rotan, Chairman (1958).
T. Charles McCormick, Jr., Buda (1962).
Dick K. Cason, Hillsboro (1962).
Roy E. Wilson, Seymour (1961).
William L. Wilson, Austin (1961).
Curtis Haley, St. Augustine (1960).
E. W. Schmidt, Pecos (1960).
George D. Bruce, Baytown (1959).
G. V. Pazdral, Somerville (1959).
J. L. Wright, Jr., Big Lake (1958).

COMMITTEE ON INDOCTRINATION

Ex officio, Chairman, Board of Trustees; Chairman, Board of Councilors; Chairman, Council on Medical Economics; Chairman, Council on Medical Jurisprudence; Chairman, Committee on Public Relations.

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[9]*Created by the resignation of Dr. Truman G. Blocker, Jr., Galveston, on June 29, 1957.*

[10]*Changed from a special to a standing committee at the 1957 annual session.*

Committee for Liaison with State Bar of Texas.—John E. Skogland, Houston, Chairman; F. C. Lowry, Austin; Carlos E. Fuste, Jr., Alvin; David J. Henry, Dallas.

Committee for Study of Health Costs.—Tom B. Bond, Fort Worth, Chairman; J. H. Wootters, Houston; George M. Hilliard, Jacksonville; Russell L. Deter, El Paso; Roy T. Lester, Dallas.

Committee on Cardiovascular Diseases.—G. A. Spikes, Hallettsville, Chairman; P. K. Smith, Wichita Falls; H. H. Latson, Amarillo; Henry M. Winans, Sr., Dallas; Robert E. Leslie, El Campo; George E. Clark, Jr., Austin; J. F. McVeigh, Fort Worth; Paul V. Ledbetter, Houston; George R. Herrmann, Galveston.

Committee on General Arrangements for Annual Session.—Hiram P. Arnold, Chairman; George Waldron; C. A. Dwyer; D. Lewis Moore; John L. Perry; Jack P. Abbott; Thomas L. Royce; Fred P. Thomas; J. T. Billups, all of Houston.

Committee on Maternal Mortality.—Garth L. Jarvis, Galveston, Chairman; E. K. Blewett, Austin; D. M. Gready, Houston; C. P. Hawkins, Fort Worth; W. H. Jondahl, Harlingen; R. E. Moon, San Angelo; William R. Knight, III, Houston; Carl F. Moore, Jr., Austin; Stewart A. Fish, Dallas.

Committee on Memorial Services.—G. W. Waldron, Houston, Chairman; Valin R. Woodward, Austin; Paul R. Stalnaker, Houston; Howard K. Crutcher, Sr., Dallas; John H. Bohmfalk, San Antonio.

Committee on Military and Veterans Affairs.—Wendell H. Hamrick, Houston, Chairman; Milton V. Davis, Dallas; James S. Reitman, Laredo.

Committee on Nuclear and Atomic Medicine.—Herbert C. Allen, Jr., Houston, Chairman; Julian H. Acker, Wichita Falls; E. E. Anthony, Jr., Fort Worth; C. C. Shullenberger, Houston; James A. Chamberlin, Houston; Lloyd R. Hershberger, San Angelo.

Committee on Problems of the Aging.—V. R. Hurst, Longview, Chairman; Wendell D. Gingrich, Galveston, Vice-chairman; Hugh P. Reveley, San Antonio; S. W. Thorn, Houston; Ernest W. Keil, Temple; E. V. Headlee, Odessa; Ben B. Hutchinson, Lubbock; Luther W. Ross, Kerrville.

Committee to Study Contract Medicine.—Sam R. Barnes, Trinity, Chairman; W. M. Wallis, Houston; Homer V. Hedges, Hico; Jack B. Lee, San Antonio; James H. Sammons, Highland.

Committee to Study Hospital-Staff Relationships.—J. Layton Cochran, San Antonio, Chairman; Everett C. Fox, Dallas; W. Shelton Barcus, Fort Worth; E. A. Rowley, Amarillo; Franklin W. Yeager, Corpus Christi.

State Committee for American Medical Education Foundation.—D. J. Sibley, Fort Stockton, Chairman; Thomas M. Runge, Austin; Luke W. Able, Houston; John R. Cook, Trinity; N. D. Boyd, Kingsville; Jack C. Postlewaite, El Paso; James R. Schofield, Houston; A. L. Delaney, Liberty; James E. Altgelt, San Antonio.

Appointees to Hospital-Insurance-Physicians Joint Advisory Committee.—Harvey Renger, Hallettsville; C. D. Bussey, Dallas.

Appointees to the State Coordinating Council on Tuberculosis.—W. D. Anderson, San Angelo; Elliott Mendenhall, Dallas.

Appointees to Texas Commission on Patient Care.—Joseph F. McVeigh, Fort Worth; G. V. Brindley, Jr., Temple; Russell D. Holt, Meridian; Vacancy.

Advisers to Texas Chapter of the Student American Medical Association.—John K. Glen, Houston, Baylor.

Appointees to Advisory Committee to the Texas State Board of Education.—J. J. Johns, Taylor.

Appointees to Advisory Committee to Texas State Hospitals and Special Schools.—E. Ivan Bruce, Jr., Galveston (Mental Health); Elliott Mendenhall, Dallas (Tuberculosis).

★ County Societies

For Tom Green: 'Clinical Day'

The Tom Green-Eight County Medical Society sponsored a Clinical Day Saturday, June 1, at the Cactus Hotel in San Angelo. A banquet and cocktail party were included in the day's events.

Also of interest to physicians in this area is the recent installation of a "number-flash" call system in the San Angelo city auditorium.

An obstetrical and gynecological out-patient clinic is being developed in connection with the city-county welfare unit in San Angelo. Approval of the project has been voted by the Tom Green-Eight County Medical Society, which suggested that a schedule for participation by cooperating members of the society be prepared.

Harris Doctors Fete Community Leaders

In observance of Medical Education Week, the public relations and executive boards of the *Harris County Medical Society* were hosts at a luncheon for 100 business and industrial leaders of the county at the Doctors' Club. Deans of all medical schools in the state were also invited. This event marked the first occasion on which the society and this group of guests met to discuss problems of mutual concern.

Programs

Recent county society programs have included:

Wilbarger County Society.—"Ureteral Calculi," Dr. J. R. Reagan, chief of the Reagan Urology Group, Wichita Falls.

Bastrop-Lee Counties Society.—"Pulmonary Insufficiency," Dr. Donald Pohl, Austin, and "Glaucoma," Dr. R. M. Rothen, Austin.

Hill County Society.—"Pediatric Emergencies," Dr. Richard N. Beskow, Hillsboro.

Harris County Society.—"Management of Lymphoma," Dr. C. C. Shullenberger; "Management of Soft Tissue Tumors," Dr. Richard Martin; and "Management of Carcinoma of the Cervix," Dr. Felix Rutledge, Houston.

Big Bend Counties Society.—"Pathology of Bone Tumors," Dr. George Turner, El Paso.

Falls County Society.—"Ulcerative Colitis—Its Diagnosis and Therapy," Dr. N. C. Hightower, Temple.

Cameron-Willacy Counties Society.—"Unconstitutionality of the Income Tax," a film; "Medical Secretaries' Workshop," Tom Edgell, Brownsville; "The Present Day Clinical Use of Radioactive Isotopes," Dr. Ruskin C. Norman, San Antonio.

Hardeman-Cottle-Foard-Motley Counties Society.—"Common Rectal Diseases and Treatments," Dr. E. A. Cox, Wichita Falls.

More Officers Reported

New officers of county societies not previously published in the *Journal* include:

Cherokee—President, Dr. H. F. Rives, Jacksonville; vice-president, Dr. F. H. Brigham, Rusk; secretary-treasurer, Dr. T. H. Cobble, Rusk; reporter and assistant secretary, Dr. Harbert Davenport, Jr., Jacksonville; delegate, Dr. G. M. Hilliard, Jacksonville.

Coleman—President, Dr. Morris D. Mann; vice-president, Dr. Roy R. Lovelady; secretary-treasurer and delegate, Dr. R. F. Kemper, all of Coleman.

Lamar—President and delegate, Dr. Courtney M. Townsend, Paris; vice-president, Dr. William D. Roberts, Paris; secretary-treasurer, Dr. H. C. Chancellor, Honey Grove.

Walker-Madison-Trinity—President, Dr. L. Ewing Bush, Huntsville; vice-president, Dr. Jesse B. Heath, Madisonville; secretary-treasurer, Dr. Eugene M. Addison, Huntsville; delegate, Dr. W. B. Veazey, Huntsville.

★ District Societies

Twelfth District Society

The Twelfth District Medical Society met in Temple July 3 and heard scientific presentations from members of the Baylor University College of Medicine staff.

Dr. Ellard M. Yow spoke on "Recent Advances in Antibiotic Therapy" and "Steroids in Systemic Infections;" Dr. E. Stanley Crawford discussed "The Modern Treatment of Arteriosclerosis," and "Hiatus Hernia and Its Complications;" Dr. Stanley F. Rogers spoke on "A Simplified Approach to Complete Perineal Repair;" and Dr. Warren M. Jacobs chose "Management of the Rh-Negative Obstetrical Patient" as his subject. All the speakers are from Houston.

At a luncheon attended by both society and auxiliary members, Dr. Ramon Tolavera spoke on the Philippine Islands.

WOMAN'S AUXILIARY

DOCTORS: THIS IS YOUR AUXILIARY

When your wife casually mentions at the dinner table in answer to your question, "What have you been doing today?" that she went to a medical auxiliary meeting, don't drop the subject there.

If you will just perk up and ask a few questions you may find that your wife hasn't been out to just another feminine gab-fest, but that she has been serving your interests well.

Let her discuss what a splendid job of public relations in their own communities the wives of Texas doctors are doing through the many projects they undertake as Auxiliary members.

Let her tell you how much active participation in the local medical auxiliary increases the awareness of the doc-

Officers of the Woman's Auxiliary to the Texas Medical Association for 1957-1958: President, Mrs. Horace S. Renshaw, Fort Worth; President-Elect, Mrs. John D. Gleckler, Denison; First Vice-President, Mrs. John H. Wootters, Houston; Second Vice-President, Mrs. J. C. Terrell, Stephenville; Third Vice-President, Mrs. Richard L. Hudson, Corpus Christi; Fourth Vice-President, Mrs. H. O. Padgett, Marshall; Fifth Vice-President, Mrs. O. N. Mayo, Brownwood; Treasurer, Mrs. William C. Barksdale, Borger; Recording Secretary, Mrs. Harold Lindley, Pecos; Corresponding Secretary, Mrs. J. Franklin Campbell, Fort Worth; Publicity Secretary, Mrs. F. C. Lowry, Austin; Parliamentarian, Mrs. Ramsay H. Moore, Dallas; Executive Secretary, Miss Hazel Casler, Austin.

tor's wife of her rare opportunity to be a good will ambassador for the medical profession.

Flatter her by expressing a real interest in the many and varied projects that auxiliaries throughout the state are undertaking for the coming year.

Here are a few for an eye-opener:

Recruitment: This year the Auxiliary is expanding its recruitment drive to include all phases of medical and x-ray technical work, dietetics, physical and occupational therapy, pharmacology, medical records library work, and social work. This is in addition to its nurse recruitment program which is already showing results.

Science Fairs: If you have had the opportunity to see young contestants in your local science fair exhibit and explain their projects you know that auxiliaries sponsoring these fairs are doing a big and important job. Young Texas scientists who competed at the Eighth National Science Fair held at Los Angeles in May walked off with one second place award and three fourth place awards. And all but one of those four national winners from Texas were Auxiliary-sponsored contestants.

Civil Defense: Civil Defense projects of some Texas Auxiliaries are amazing in their scope and in the carefully detailed plans that have been worked out in case of any kind of community disaster. Doctors' wives can do much to stir up local interest in civil defense programs and to combat the attitude of so many citizens that "It can't happen here."

Mental Health: Auxiliary members throughout the state are working hard on the problem of mental health. Some are working in child guidance clinics and clinics for retarded children. Some are serving on county and state boards. And throughout the state the young and the old, the sick and the helpless are being remembered, entertained, encouraged, and helped by doctors' wives who are determined that they shall not be forgotten or neglected because their homes are institutions.

AMEF: Last year Texas Auxiliaries gave more than $10,000 to the AMEF. This year they hope to give more, as they are pushing their newest money-making project, the selling of Christmas cards, with all profits earmarked for the AMEF.

Legislative: Auxiliary members are deeply interested in legislation that either directly or indirectly affects the medical profession. Through their auxiliaries they learn the most effective means of making their voices heard and are encouraged and reminded to be active politically.

Library Fund: Our contributions to the Library Fund are being used to buy books and films for the Memorial Library of the Texas Medical Association. Also, members are being encouraged to turn over to the Medical Library books from private collections that are no longer in use because of the death or retirement of their owners.

Memorial Fund: Auxiliary members contribute each year to the Memorial Fund from which the Auxiliary makes cash gifts to take care of the financial needs of widows and dependents of Texas doctors. In doing for others, doctors' wives are not forgetting their duty to look after their own.

These are by no means all of the ways in which Auxiliary members are striving to back up the medical profession and to use their opportunities as doctors' wives to better their communities.

In the months to come the space in the *Texas State Journal of Medicine* that has been designated for Auxiliary news will be used to tell more about Auxiliary projects.

Why not take a few minutes from your busy lives to find out what your Auxiliary is doing and, even more important, how your own wife is trying to be a real help-mate in the finest, most modern meaning of that old-fashioned term.

Remember: It is your Auxiliary.

—MRS. FREDERICK C. LOWRY, Austin.

RECENT DEATHS

DR. LUBA E. ANIGSTEIN

Dr. Luba Esther (Heller) Anigstein, Galveston, Texas, died April 14, 1957. She was born February 14, 1891, in Wolkowysk, Poland (now Russia) and attended Gymnasium at Bialystok, Russia; the University of Berlin, Medical Faculty; and was graduated from the Medical Faculty of the Imperial Russian University at Dorpat, Estonia, 1915. Dr. Anigstein then served during World War I as a physician with the Russian Red Cross until 1918, when she interned and became an assistant in the Department of Pediatrics, University of Warsaw, Poland. Five years later, she began her work as pediatrician for the Ministry of Social Welfare in Warsaw, a position which she held until 1939. After coming to America, Dr. Anigstein passed the required examinations to practice medicine and surgery in New York (1944) and Texas (1948). She also was school physician for the Galveston public schools until 1949, when she opened her private practice, which she maintained until the

DR. LUBA E. ANIGSTEIN

time of her death. Dr. Anigstein completed several postgraduate courses given by the Department of Pediatrics of the University of Texas Medical Branch where she was holding the appointment of assistant in pediatrics.

Dr. Anigstein was a member of the Texas and American Medical Associations through Galveston County Medical Society, the University Women's Club, Alpha Epsilon Iota women's medical sorority, Galveston Art League, Temple B'nai Israel, Council of Jewish Women, Young Women's Christian Association, Rosenberg Library, and Altrusa International, which she served as chairman of the committee on

An obituary ordinarily will not be published more than four months after date of death. Cooperation in reporting deaths of physicians and in furnishing appropriate biographical material promptly is solicited.

international relations. As hobbies, she enjoyed interior decoration and mathematics.

Dr. Ludwik Anigstein and Dr. Luba Anigstein were married April 16, 1916, in Petrograd, Russia. Dr. Anigstein survives, as do two children, Alice H. Grynbaum, New York; and Robert Anigstein, Chicago; four sisters, Sophie I. Seidenman, New York; Dora Ginsburg, Moscow, Russia; Fanny Fenster, Tel-Aviv, Israel; Anna B. Lazicka-Hermelin, Zabrze, Poland; and three brothers, Joseph Heller, New York; Jacob Heller, Zurich, Switzerland; and Vladimir Heller, Moscow, Russia.

DR. GORDON A. LILLIE

Dr. Gordon Albert Lillie, Baytown, died April 10, 1957, of chronic glomerulonephritis with uremia.

Dr. Lillie was born in Sumner County, Kan., June 13, 1887, son of Albert F. and Gertrude H. Lillie. He attended Texas Christian University, Fort Worth, where he received both academic and medical education, receiving his doctor of medicine degree in 1912. After interning at Buffalo Park Sanitarium and Fort Worth City Hospital, Dr. Lillie practiced briefly in Oklahoma, first in Pawnee and then in Stillwater, before locating in Texas. From 1914 until 1919 he was at Batson; since 1919 he had been in practice in Goose Creek and Baytown. He and Dr. H. H. Duke built the Lillie-Duke Hospital in Baytown in 1936.

A member of the Harris County Medical Society and affiliated organizations, Texas Medical Association, and American Medical Association, Dr. Lillie was first president

DR. GORDON A. LILLIE

of the East Harris County Medical Society. He belonged to Phi Chi fraternity, the Masonic Lodge, and the Presbyterian Church. He was vice-president of the First National Bank of Baytown and a partner in the Newton-Lillie Oil Company before it was sold to another company. During World War I he was a first lieutenant in the Army and during World War II a medical examiner for Selective Service.

Dr. Lillie is survived by his wife, the former Miss Elizabeth Vandervoort of Pawnee, Okla., whom he married April 15, 1914; a son, Dr. Gordon V. Lillie, Odessa; a sister, Miss Garnet Lillie, Pawnee, Okla.; and three grandchildren.

DR. SAMUEL O. LEVIN

Dr. Samuel Orrin Levin, Denison, died in that city on April 6, 1957.

He was born on October 30, 1908, in Quebec, Canada, the son of Oscar and Sonia (Vinocurov) Levin. After receiving his preliminary education in Chicago, he received from the University of Illinois his bachelor of science and his medical degrees, the latter in 1933.

Dr. Levin interned and took his medical residency at Cook County Hospital in Chicago, following that with a surgical residency at Woodlawn Hospital in the same city. He practiced briefly in Amarillo in 1936, then for a year

DR. SAMUEL O. LEVIN

at the Conchas Dam, N. Mex., project. From 1939 until 1957, he was a general practitioner in Denison, serving in the Army Reserve Medical Corps for one year during that period.

He was a member of the Grayson County Medical Society (serving as president in 1945), Texas Medical Association, American Medical Association, and the American Academy of General Practice. He was of the Jewish faith.

In Lubbock, on April 25, 1938, Dr. Levin married Miss Mary Dell Jacobs of Flora, Ill. He is survived by his wife; two children, Lawrence David Levin and Mary Karen Levin, both of Denison; a sister, Mrs. Ida Passin of Culver City, Calif.; and two brothers, Harry and Morris Levin, both of Chicago.

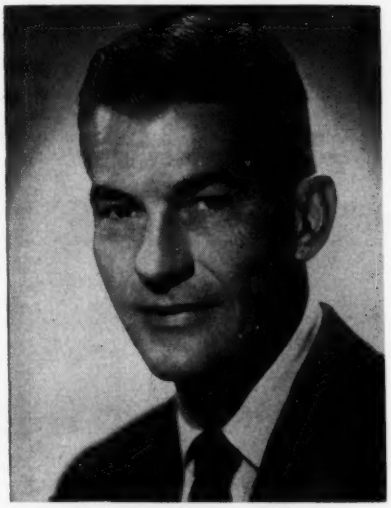
DR. CHARLES N. LaDUE

Dr. Charles Nance LaDue, internist, diagnostician, and cardiologist, died May 1, 1957, in his office in Dallas following a cerebral hemorrhage.

Dr. LaDue was the son of Milton J. and Edna (Nance) LaDue and was born September 15, 1913, in Dallas. After attending Southern Methodist University, Dallas, for two years, he was graduated from the University of Texas, Austin, and went on to the University of Texas Medical Branch, Galveston, to receive his doctor of medicine degree in 1938. Dr. LaDue served an internship at Kansas City General Hospital and a residency at Dallas City-County Hospital.

From 1941 until his death, he was in practice in Dallas with the exception of three and one-half years spent with the Army Medical Corps. He was a major with the Fifty-Sixth Evacuation Hospital (Baylor Unit) in the Mediterranean Theater. He was clinical instructor of internal medicine at Southwestern Medical School of the University of Texas.

A member throughout his career of the Dallas County Medical Society, Texas Medical Association, and American Medical Association, Dr. LaDue was a fellow of the American College of Physicians, a diplomate of the American Board of Internal Medicine, and a member of the Texas



DR. CHARLES N. LaDUE

Club of Internists, Dallas Academy of Internal Medicine, and Dallas Southern Clinical Society. He belonged to the Highland Park Methodist Church.

He is survived by his wife, the former Miss Joyce Standifer; three children, Nancy, Linda, and Jane; two brothers, Milton J. LaDue, Jr. and Jack W. LaDue; and his mother, Mrs. Edna LaDue, all of Dallas.

DR. R. S. WILLIS

Dr. Raymond Shelfer Willis, Dallas surgeon, died April 27, 1957, of a liver ailment.

Son of W. E. and Mary Etta (Wilcox) Willis, Dr. Willis was born August 18, 1903, in Coolidge. He obtained his preliminary education in Dallas, attended North Texas Agricultural College at Arlington and Southern Methodist University at Dallas, and received his medical degree from Baylor University College of Medicine at Dallas in 1933. After serving an internship and a residency in surgery at Baylor Hospital, Dallas, Dr. Willis remained in Dallas to practice. He was president of the East Dallas Hospital and Clinic.

Dr. Willis belonged to the Dallas County Medical Society, Texas Medical Association, American Medical Association, Masonic Lodge, Baptist Church, Lambda Chi Alpha social fraternity, Phi Chi medical fraternity, and Alpha Omega Alpha honorary medical fraternity. During World War II he served four years in the African-European Theater as assistant chief and later, for a few months, chief of surgery for the Fifty-Sixth Evacuation Hospital, holding the rank of major and then lieutenant colonel. Dr. Willis was an able pianist.

Surviving Dr. Willis are his wife, the former Miss Mattie Lou Frye, whom he married February 2, 1935, in Dallas; his mother, Mrs. W. E. Willis, Dallas; and two brothers, Dr. W. Darrell Willis, now a colonel in the Army stationed at Fort Hood, and Curtis E. Willis of Dallas.

DR. EDGAR W. ANDERSON

Dr. Edgar W. Anderson, Conroe, died in a Houston hospital May 11, 1957, having been in semiretirement for about a year.

Born in Hart, Mich., on May 15, 1901, Dr. Anderson was the son of the late Mr. and Mrs. William Anderson. He attended grade and high schools in Scottville, Mich., received bachelor of arts and bachelor of science degrees from the University of Michigan, and received his medical degree from the University of Arkansas in Little Rock in 1928. His internship was served at St. Joseph's Hospital in Houston.

From 1930 until 1934, Dr. Anderson was medical supervisor of the Texas Prison System, headquartered at Huntsville. He joined the staff of the Walker County Hospital in 1934 and remained until 1945, during which time he was also engaging in an independent practice of medicine and surgery at Huntsville.

In 1945 Dr. Anderson moved to Conroe, where he prac-

DR. EDGAR W. ANDERSON

ticed until some months before his death. He was president of the Walker-Madison-Trinity Counties Medical Society in 1932, was later a member of the Montgomery County Society (being president in 1950), and belonged to the Texas, American, and Southern Medical Associations.

Dr. Anderson was very active in community life. In 1940, he was elected mayor of Huntsville, and he was president of the Conroe Independent School Board—on which he served continuously from 1951—at the time of his death. He was a stockholder in both of the Conroe banks, a member of the Chamber of Commerce, the Masonic Order, Conroe Country Club, past president of the Lions Club in

Huntsville, and a stockholder and director of the Conroe Community Hotel. He enjoyed golf, hunting, fishing, and gin rummy as hobbies. He was an Episcopalian.

The physician is survived by his wife, Mrs. Irene Pankhurst Anderson, Conroe; three daughters, Mrs. B. B. Bolton of Edna, Mrs. Jake Posey of Conroe, and Mrs. J. R. Wright of Oceanside, Calif.; one sister, Mrs. Myrtle Parmelee of Muskegan, Mich.; and four grandchildren.

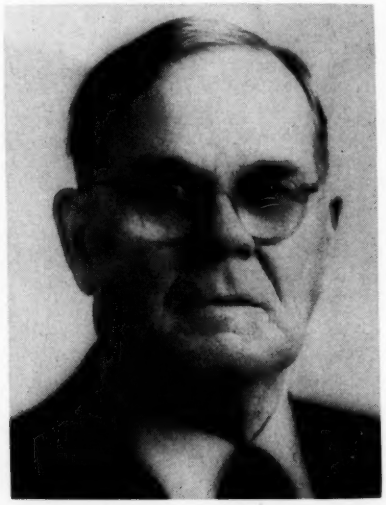
DR. TIM H. PARMLEY

A highway auto accident near Medford, Okla., on April 15, 1957, took the life of Dr. Tim Hennessey Parmley, pioneer Electra physician.

Dr. Parmley was born in Madisonville in 1883. He attended public schools in Portales, N. Mex.; East Texas Teachers College in Commerce; and Memphis Hospital Medical College in Tennessee, from which he received his medical degree in 1912. He interned at Memphis Hospital and then practiced in Electra from 1913 until his death.

A member of the Wichita County Medical Society, which he served as president in 1926, and the American Medical Association, Dr. Parmley was elected to honorary membership in the Texas Medical Association in 1954. He was a member of the First Methodist Church of Electra. Keenly interested in agricultural development, he owned and operated a farm northwest of Electra on which he conducted experiments with range and pasture grasses.

Dr. Parmley married the former Miss Madge Doggett in Memphis in 1913.



DR. TIM H. PARMLEY

He died from shock shortly after the car in which he was riding overturned 5½ miles south of Medford on U. S. Highway 81. Mrs. Parmley, driver of the vehicle, was not injured.

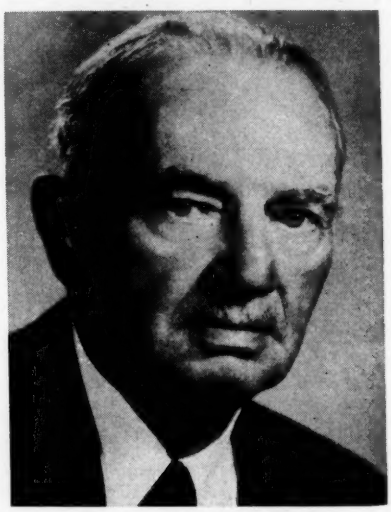
Surviving are his wife; a daughter, Mrs. A. E. Reid, Kerrville; four sons, Dr. Van S. Parmley and Dr. Ray T. Parmley, both of Wichita, Kan., Dr. John B. Parmley of New Orleans, and Ralph Parmley of Mendham, N. J.; two brothers, Dr. L. E. Parmley of Winter Haven, Fla., and B. E. Parmley of Midland; and three sisters, Mrs. Robert Green of Vernon, Mrs. John Caldwell of Madison, and Mrs. Ed Parker of Frederick, Okla.

DR. ARTHUR T. TALLEY

Dr. Arthur Thurman Talley, Kerrville, died in a Houston hospital May 11, 1957. He was president of the Harris County Medical Society in 1939 and a practicing physician in Houston for 36 years.

Dr. Talley was born July 15, 1888, in Brantley, the son of Monroe and Fannie Talley. After attending public schools in Conroe, he studied at Tulane University in New Orleans, where he received his medical degree in 1914. He interned at Southern Pine Lumber Company Hospital in Diboll and did postgraduate work at Tulane and at the University of Pennsylvania.

The physician practiced briefly in Conroe and Diboll before moving to Houston in 1920. He served on the staffs of Methodist, Jefferson Davis, St. Joseph's, and Memorial Hospitals, and was president of the staff of the latter in 1936. He also conducted a private practice in obstetrics and gynecology during his years in that city. In 1956, he moved to Kerrville to join the staff of the Sid Peterson Memorial Hospital.



DR. ARTHUR T. TALLEY

Dr. Talley was a fellow of the American College of Surgeons. His other memberships included the American Medical Association, Texas Medical Association, and Texas Society of Obstetricians and Gynecologists, and he served on nearly every board of the Harris County Medical Society. In 1952, he was elected to honorary membership in the Texas Medical Association, and he transferred his local membership to Kerr-Kendall-Gillespie-Bandera Counties Medical Society last year.

In addition, he was a member of the Methodist Church, Rotary International, Masonic Lodge, Scottish Rite bodies, Shrine, and Knights of Pythias. His hobby was golf.

Dr. Talley's first wife, the former Miss Tommy Robertson, whom he married in Conroe on June 7, 1911, died on March 15, 1954.

He is survived by his wife, Mrs. Murriel Talley of Kerrville; a son, Dr. A. T. Talley, Jr., head of the Department of Obstetrics at Memorial Hospital, Houston; a second son, Monroe R. Talley, Houston; three daughters, Mrs. W. E. Maxwell and Mrs. Buell E. Sweeton, Houston, and Mrs. Walter L. Judd, Richmond, Va.; and a sister, Mrs. Frank Sterrett, Houston.

MEMBERSHIP

TEXAS MEDICAL ASSOCIATION

JULY, 1957

The membership list which follows is compiled from names sent by county society secretaries to the state office. The names are listed by county societies within the fifteen districts. The number after each county listed below indicates the district in which the county is located.

Anderson—11
Andrews—2
Angelina—10
Aransas—6
Archer—13
Armstrong—3
Atascosa—5
Austin—9
Bailey—3
Bandera—5
Bastrop—7
Baylor—13
Bee—6
Bell—12
Bexar—5
Blanco—7
Borden—2
Bosque—12
Bowie—15
Brazoria—8
Brazos—12
Brewster—1
Briscoe—3
Brooks—6
Brown—4
Burleson—9
Burnet—7
Caldwell—7
Calhoun—8
Callahan—13
Cameron—6
Camp—15
Carson—3
Cass—15
Castro—3
Chambers—10
Cherokee—11
Childress—3
Clay—13
Cochran—3
Coke—4
Coleman—4
Collin—14
Collingsworth—3
Colorado—8
Comal—5
Comanche—4
Concho—4
Cooke—14
Coryell—12
Cottle—3
Crane—4
Crockett—4
Crosby—3
Culberson—1
Dallam—3
Dallas—14
Dawson—2
Deaf Smith—3
Delta—14
Denton—14
De Witt—8
Dickens—2
Dimmit—5
Donley—3
Duval—6
Eastland—13
Ector—2
Edwards—5
Ellis—14
El Paso—1
Erath—12
Falls—12
Fannin—14
Fayette—8
Fisher—2
Floyd—3
Foard—3
Fort Bend—8
Franklin—14
Freestone—11
Frio—5
Gaines—2
Galveston—8
Garza—2
Gillespie—5
Glasscock—2
Goliad—8
Gonzales—5
Gray—3
Grayson—14
Gregg—15
Grimes—9
Guadalupe—5
Hale—3
Hall—3
Hamilton—12
Hansford—3
Hardeman—3
Hardin—10
Harris—9
Harrison—15
Hartley—3
Haskell—13
Hays—7
Hemphill—3
Henderson—11
Hidalgo—6
Hill—12
Hockley—3
Hood—12
Hopkins—14
Houston—11
Howard—2
Hudspeth—1
Hunt—14
Hutchinson—3
Irion—4
Jack—13
Jackson—8
Jasper—10
Jeff Davis—1
Jefferson—10
Jim Hogg—6
Jim Wells—6
Johnson—12
Jones—13
Karnes—5
Kaufman—14
Kendall—5
Kenedy—6
Kent—2
Kerr—5
Kimble—4
King—2
Kinney—5
Kleberg—6
Knox—13
Lamar—14
Lamb—3
Lampasas—7
La Salle—5
Lavaca—8
Lee—7
Leon—11
Liberty—10
Limestone—12
Lipscomb—3
Live Oak—6
Llano—7
Loving—1
Lubbock—3
Lynn—2
McCulloch—4
McLennan—12
McMullen—6
Madison—9
Marion—15
Martin—2
Mason—4
Matagorda—8
Maverick—5
Medina—5
Menard—4
Midland—2
Milam—12
Mills—4
Mitchell—2
Montague—13
Montgomery—9
Moore—3
Morris—15
Motley—3
Nacogdoches—10
Navarro—12
Newton—10
Nolan—2
Nueces—6
Ochiltree—3
Oldham—3
Orange—10
Palo Pinto—13
Panola—11
Parker—13
Parmer—3
Pecos—1
Polk—9
Potter—3
Presidio—1
Rains—14
Randall—3
Reagan—4
Real—5
Red River—15
Reeves—1
Refugio—6
Roberts—3
Robertson—12
Rockwall—14
Runnels—4
Rusk—11
Sabine—10
San Augustine—10
San Jacinto—9
San Patricio—6
San Saba—4
Schleicher—4
Scurry—2
Shackelford—13
Shelby—10
Sherman—3
Smith—11
Somervell—12
Starr—6
Stephens—13
Sterling—4
Stonewall—2
Sutton—4
Swisher—3
Tarrant—13
Taylor—13
Terrell—5
Terry—2
Throckmorton—13
Titus—15
Tom Green—4
Travis—7
Trinity—9
Tyler—10
Upshur—15
Upton—4
Uvalde—5
Val Verde—5
Van Zandt—14
Victoria—8
Walker—9
Waller—9
Ward—1
Washington—9
Webb—6
Wharton—8
Wheeler—3
Wichita—13
Wilbarger—13
Willacy—6
Williamson—7
Wilson—5
Winkler—1
Wise—13
Wood—11
Yoakum—2
Young—13
Zapata—6
Zavala—5

(Int.) indicates Intern Membership. (Hon.) indicates Honorary Membership. (Emer.) indicates Membership Emeritus. (Inac.) indicates Inactive Membership. (Mil.) indicates Military Membership.

FIRST DISTRICT

Dr. C. E. Oswalt, Jr., Fort Stockton, Councilor

EL PASO

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Gaddis, William R., 1218 Mills Bldg., El Paso.
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Gallagher, Paul, (Hon.),
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Goodloe, B. Lynn,
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Green, Charles L.,
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King, Sam R., 607 El Paso Natl. Bldg., El Paso.
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Mason, Claude H., (Hon.),
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McNeil, James Lewis,
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McVaugh, Charles C., 616 Mills Bldg., El Paso.
Milchen, Carl, 7505 N. Loop Rd., El Paso.
Miller, John B., 3313 Fort Blvd., El Paso.
Miskimins, J. Harry, Mills Bldg., El Paso.
Molinar y Rey, Jose, (Inac.),
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Molloy, Maxwell S., 502 Cincinnati, El Paso.
Morrison, John E., Mills Bldg., El Paso.
Morrow, Walter G., Jr.,
1001 1st Natl. Bldg., El Paso.
Moses, Lyndon D., 8200 Dyer St., El Paso.
Multhauf, A. W., 1315 1st Natl. Bldg., El Paso.
Munick, Reuben, 112 S. Concepcion, El Paso.
Nering, A. Robert, 1st Natl. Bldg., El Paso.
Palafox, Mario, 520 Montana St., El Paso.
Peer, George F., (Mil.), WBAH, El Paso.
Perry, Alvin L., 209 Med. Arts Bldg., El Paso.
Persky, Murray, 631 Turney Blvd., El Paso.
Peticolas, John D.,
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Phillips, Richard J., (Mil.),
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Price, Elwyn D., (Inac.),
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Quirarte, Humberto,
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Ramirez, Jose Rivera, (Mil.),
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Redelfs, John Wright,
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Rennick, Charles F., 1218 Mills Bldg., El Paso.
Reynolds, Chester Lee,
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Reynolds, George A., (Mil.), El Paso.
Rheinheimer, E. W.,
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Rice, Herman, 1501 Arizona St., El Paso.
Rigney, Paul, 821 E. Yandell Blvd., El Paso.
Rising, Ernest E., Jr., (Mil.),
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Rissler, Ross W., 2001 Grant Ave., El Paso.
Robbins, Jacob B., 927 1st Natl. Bldg., El Paso.
Rodarte, Ruben B., 401 S. Stanton, El Paso.
Rogde, Jacob, 315 Mills Bldg., El Paso.
Rogers, S. Perry, 1501 Arizona St., El Paso.
Rush, Jack T., (Mil.),
Fitzsimons Army Hosp., Denver, Colo.
Samp, Bernard A., 3317 Fort Blvd., El Paso.
Schlenker, George M.,
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Schuessler, Willard W.,
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Schuster, Frank P., 1st Natl. Bldg., El Paso.
Schuster, Frank P., Jr. (Mil.),
Fort Bliss, El Paso.
Schuster, Stephen A., 1st Natl. Bldg., El Paso.
Shanley, T. J. B., 8903 Old County Rd., Ysleta.
Shugart, Joseph A., 1501 Arizona St., El Paso.
Skemp-Nystrom, Harriet, Box 25, Canutillo.
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Soto, Raul C., 522 Caples Bldg., El Paso.
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Spier, Erich, 415 E. Yandell Blvd., El Paso.
Stanfill, Chas. M.,
415 E. Yandell Blvd., El Paso.
Stapp, Celso C., 800 Montana St., El Paso.
Stern, J. Edward, 626 Mills Bldg., El Paso.
Stevens, B. F. (Hon.), 217 Blacker, El Paso.
Stowe, Jesson L., 2323 Montana St., El Paso.
Stratemeyer, W. P.,
415 E. Yandell Blvd., El Paso.
Thomas, Merle D., 1501 Arizona St., El Paso.
Thompson, Robert F. (Pres.),
818 Mills Bldg., El Paso.
Treece, Angus A., Fabens.
Tubbs, William M., 3031 Altura, El Paso.
Turner, George 1501 Arizona St., El Paso.
Unger, Albert H.,
911 Huckleberry Rd., El Paso.
Vance, James (Hon.),
1717 N. Mesa Ave., El Paso.
Vandevere, William E.,
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Vargas, G. Francisco, 408 S. Stanton, El Paso.
Varner, Harry H., 1501 Arizona, 5E, El Paso.
Verosky, John M., 1501 Arizona St., El Paso.
Villareal, Leopoldo, Caples Bldg., El Paso.
Vinikoff, Maurice R., 318 Mills Bldg. El Paso.
Voigt, Alfred E., 4806 Montana St., El Paso.
Von Briesen, Delphin,
1501 Arizona St., El Paso.
Walker, Jack A., Jr.,
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Walker, Newton F., 1st Natl. Bldg., El Paso.
Webb, Charles E., 1501 Arizona St., El Paso.
Wilcox, Leigh E., 1501 Arizona St., El Paso.
Wollmann, Walter W.,
2001 Grant Ave., El Paso.
Zehm, Abner, (Mil.), Fort Ord, Calif.

PECOS-JEFF DAVIS-PRESIDIO-BREWSTER

Blackwell, James H. (Hon.), Marfa.
Gaddis, Don A., Fort Davis.
Gipson, James F.,
211 N. Nelson, Fort Stockton.
Hill, Malone V., 123 N. Sixth St., Alpine.
Hoffman, George A.,
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Hundley, John C. (Sec'y),
Box 466, Fort Stockton.
Kelley, Wm. N. (Hon.),
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Lockhart, William E., Jr., Alpine.
Oswalt, Chas E., Jr.,
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Pate, John W. (Pres.),
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Raine, M. F., Memorial Hosp., Stanton.
Searls, John P., Marfa.
Sexton, Jack M., 102 N. Persimmon, Sanderson.
Sherrod, Vincent A., Box 608, Iraan.
Sibley, D. J., Jr., Box 367, Fort Stockton.
Stover, Walter H., Marfa.
Wright, Joel E., Box 697, Alpine.

REEVES-WARD-WINKLER-LOVING-CULBERSON-HUDSPETH

Camp, Jim, Pecos.
Gibson, Joseph V., Jr. (Sec'y),
110 N. Poplar, Kermit.
Heath, Joe D., 113 S Mulberry, Kermit.
Kunstadt, Paul, Monahans.
Lindley, Harold, Pecos.
McClure, Wayne H., Kermit.
Munk, Otto, Monahans.
Peddicord, Harper II, 900 Jeffe Dr., Kermit.
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Rehmeyer, Walter O., Monahans.
Roberts, Rufus A., Pecos.
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Robinson, Lila Rose, Box 487, Kermit.
Schmidt, Ed W., Pecos.
Wight, Bennett A. 113 S. Mulberry, Kermit.

SECOND DISTRICT

Dr. Henrie E. Mast, Midland, Councilor

ANDREWS-ECTOR-MIDLAND

Autry, Paul G., 2010 W. Illinois, Midland.
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Bryan, John N., 1600 N. Texas St., Odessa.
Buck, Roger, 304 North N, Midland.
Bugg, Robert N., 208 N. Garfield, Midland.
Cantrell, David E., 516 W. 4th St., Odessa.
Carson, Willis T., 506 N. Alleghaney, Odessa.
Chapple, James H. (Inac.),
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Clark, John L., Jr., 1200 N. Texas, Odessa.
Coleman, Jesse L., 210 North C St., Midland.
Colquitt, Landon A. (Int.),
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Cone, Jesse D., 318 N. Alleghaney, Odessa.
Connery, David B., 2006 W. Ohio, Midland.
Craven, John J., 313-B N. Alleghaney, Odessa.
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Elliott, Vance J., Medical Arts Clinic, Odessa.
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Furst, William D., 601 W. 4th St., Odessa.
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Mast, Henrie E., 2203 W. Illinois, Midland.
Mast, John R., 2203 W. Illinois, Midland.
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BORDEN-DICKENS-GARZA-KENT-KING-SCURRY-STONEWALL

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Hartley, Thomas F. (Sec'y),
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Williams, Pat, 723 N. Carroll, Spur.

DAWSON-LYNN-TERRY-GAINES-YOAKUM

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Dow, Harold D., Seminole.
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Koberg, Frederick J., Seminole.
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Price, Noble H., Lamesa.
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Prohl, Emil H., Tahoka.
Puckett, John P., Lamesa.
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Sharp, Joseph E., Denver City.
Smith, Alfred H., Lamesa.
Staker, Norman W. (Sec'y), Lamesa.
Thomas, C. Skiles, Tahoka.
Tinley, Robert E., Denver City.
Treadaway, Thomas L., Brownfield.
Watts, Maurice A., Denver City.

HOWARD-MARTIN-GLASSCOCK

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Cowan, W. Kenneth,
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Johnson, Bruce H., Loraine.
Johnson, Clark A.,
Young Medical Center, Sweetwater.
Johnson, J. Frank, Rotan.
Lebleu, Bennie, P. O. Box 473, Rotan.
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Logsdon, Harry A., Colorado City.
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Peters, Roland O., Sweetwater.
Price, Robert L., Sweetwater.
Rhode, Oscar E., Colorado City.
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THIRD DISTRICT

Dr. Robert A. Neblett, Canyon, Councilor

ARMSTRONG-DONLEY-CHILDRESS-COLLINGSWORTH-HALL-WHEELER

Blackketter, Donald E.,
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Chaffin, Curtis R.,
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Fox, Jack F., 801 Commerce St., Childress.
Gooch, James W., Shamrock.
Goodall, O. R., Memphis.
Holcomb, Carter, Wellington.
Hunt, Thurman A., Memphis.
Jenkins, O. L. (Hon.),
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Jernigan, James H. (Hon.), Childress
Jeter, Perry R. (Hon.), Childress.
Jones, Charles B. (Pres.), Wellington.
Jones, Elmer W. (Hon.),
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Nicholson, Harold E., Sr., Wheeler.
Nicholson, Harold E., Jr., Wheeler.
Odom, James A. (Hon.), Box 706, Memphis.
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Smith, George W., Adair Hospital, Clarendon.
Stevenson, Harold R., Memphis.
Townsend, Shell H., Childress.
Walker, Glenn R., Wheeler.
Watkins, Dale V. (Sec'y), Wellington.
Westenburg, Jacobus J., Childress.

DALLAM-HARTLEY-SHERMAN-MOORE

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Pieratt, Karl W., 124 Amherst, Dumas.
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Richardson, O. J., 201 Bliss, Dumas.
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GRAY-HANSFORD-HEMPHILL-LIPSCOMB-ROBERTS-OCHILTREE-HUTCHINSON-CARSON

Ashby, Charles H.,
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Barksdale, William C.,
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Beach, Wm W. (Hon.),
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Bellamy, Russell M.,
Combs Worley Bldg., Pampa.
Bertinot, C. Walter,
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Brothers, Joe F. (Sec'y),
412 S. Main, Borger.
Brown, R. Malcolm (Pres.),
Florida & Hobart, Pampa.
Davis, Jesse J. (Hon.), Higgins.
Donaldson, Joe R., Hughes Bldg., Pampa.
Elder, John F., 600 W. Kentucky, Pampa.
Ellis, Neely Joe,
Combs Worley Bldg., Pampa.
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Holmes, Robert L., Jr.,
Phillips Med. Center, Phillips.
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Huff, Oscar (Hon.),
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Pearson, Daniel B., Jr., Perryton.
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Sanford, Roy K., Perryton.
Snyder, Edward H. (Hon.), Canadian.
Snyder, Rush A., 405 Main St., Canadian.
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Stephens, Walton G., 412 Main, Borger.
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Davis, Jeff H. (Sec'y),
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Dils, Grover C., Caliente, Nevada.
Dye, Everette L.,
314 Skaggs Bldg., Plainview.
Dye, Mary R., 312 Skaggs Bldg., Plainview.
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Freeman, Ray W., Hale Center.
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Horn, Joe J., 220 St. Louis, Plainview.
Howell, McKinley,
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Jackson, Carl C., 706 Denver St., Plainview.
Johnson, Gilmer B., Jr.,
211 Skaggs Bldg., Plainview.
Long, Dorothy C., Skaggs Bldg., Plainview.
Long, John C., 801 W. 8th, Plainview.
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Nichols, E. O., Sr.,
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George, Joseph M., Quanah.
Harmon, Franklin C., Jr., Paducah.
Hughes, John F., Spur.
McDaniel, Robert R., Quanah.
Pate, Clarence C., Paducah.
Powell, Burrell E.,
Chillicothe Clinic, Chillicothe.
Raines, John W., Crowell.
Salkeld, Phil L., Quanah.
Sitta, Raymond E., Chillicothe.
Stanley, James S., Matador.
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Campbell, Dale P. (Pres.), Levelland.
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Shotwell, Ira T., Jr., Littlefield.
Stafford, Delmon J.,
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Still, Oscar W., Littlefield.
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LUBBOCK-CROSBY

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Ansley, Leslie R., 2615 19th St., Lubbock.
Arnett, Sam C., Jr., 2609 19th St., Lubbock.
Arnold, Robert N., 1910 Knoxville, Lubbock.
Barsh, Albert G., 2010 Broadway, Lubbock.
Batson, Carey B., 1315 10th St., Lubbock.
Baugh, William L., (Hon.),
1302 Main St., Lubbock.
Birdsong, William F., Muleshoe.
Black, Crawford H., Silverton.
Blake, Emerson M., 1910 Knoxville, Lubbock.
Bronwell, Alvin W., (Sec'y.),
1910 Knoxville, Lubbock.
Canon, Robert T., 1312 Main St., Lubbock.
Carnrick, Millard, Jr.,
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Croom, William S., 1910 Knoxville, Lubbock.
Cross, Denzil D., 1312 Main St., Lubbock.
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Haney, Edward L., Ralls.
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Jaynes, Stan H., 825 W. Lubbock St., Slaton.
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Smith, Roy L., 1910 Knoxville, Lubbock.
Smith, William C., 1910 Knoxville, Lubbock.
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POTTER

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Walkes, Ernest E., V. A. Hosp., Amarillo.
Watkins, Walter C., 606 W. 8th, Amarillo.
Werner, Jan R., 2307 W. 7th, Amarillo.
Wertz, Royal F., 213 Amarillo Bldg., Amarillo.
Wheir, William H., 2400 Line Ave., Amarillo.
White, Jesse B., 518 Amarillo Bldg., Amarillo.
Winsett, Amos E., 611 Fisk Bldg., Amarillo.
Winsett, E. Merrill, 611 Fisk Bldg., Amarillo.
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Witt, John E., (Int.),
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Wolfson, Charles, 2718 W. 10th, Amarillo.
Wyatt, George W., 1422 Tyler St., Amarillo.
Wyatt, James Odis,
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Yeakel, S. Victor, 2400 Line Ave., Amarillo.

RANDALL-DEAF SMITH-PARMER-CASTRO-OLDHAM-SWISHER

Barnett, Lewis B, Box 986, Hereford.
Bischoff, Harold W., P. O. Box 488, Dimmitt.
Boswell, Leta N., (Pres.), Canyon.
Burk, Houston M., 200 N. Austin, Tulia.
Childress, Wm. B., 118 S W 1st St., Tulia.
Cogswell, Ronald E., Dimmitt.
Foreman, Lee S., (Mil.),
1215 S. Phillips, Sioux Falls, S. Dak.
Grubbs, Roy J., Box 552, Hereford.
Jarrett, Robert P., Canyon.
Lawrence, William D., 420 Star, Hereford.
Loyd, Oscar H., (Hon.), Vega.
Mims, Arthur T., Hereford.
Moore, G. Dudley, Jr., (Sec'y.),
Box 35, Canyon.
Neblett, Robert A,
Neblett Hosp. & Cl., Canyon.
Nester, Chas. R., Canyon.
Nobles, Millard W.,
111 N. Knight St., Hereford.
Page, Carl F., Box 188, Dimmitt.
Richards, Fred V., Tulia.
Spence, Joseph W., Jr., Box 188, Dimmitt.
Spring, Floyd Lee, Friona.
Spring, Paul L., Friona.
Stewart, Evans P., Tulia.
Wills, Ralph R., Hereford.

FOURTH DISTRICT

Dr. O. H. Chandler, Ballinger, Councilor

BROWN-COMANCHE-MILLS-SAN SABA

Allen, Homer B., Sr., Box 790, Brownwood.
Benson, William F., (Pres.),
Medical Arts Clinic, Brownwood.
Bullard, Chester C., (Hon.), Brownwood.
Cadenhead, Ernest F.,
2401 Coggin Ave., Brownwood.
Childress, Marvin A., Goldthwaite.
Farley, Frederick W., San Saba.
Felts, Richard C., San Saba.
Galbreath, John C., (Mil.), Brownwood.
Gold, Philip S., (Sec'y), Brownwood.
Gray, Charles W., (Hon.), Comanche.
Hallum, Roy G.,
409 E. Adams St., Brownwood.
Hames, Frederick W.,
1505 Eleventh St., Brownwood.
Hughes, Sidney W.,
Citizens Natl. Bk. Bldg., Brownwood.
Lobstein, Henry L.,
1319 Austin Ave., Brownwood.
Locker, Harry L., Rt. 3, Brownwood.
Locker, S. Braswell, 1501 11th St., Brownwood.
Mayo, Oscar N., Box 790, Brownwood.
McFarlane, Joe R.,
Citizens Bank Bldg., Brownwood.
McGowan, Patrick T.,
Med. Arts Clinic, Brownwood.
Nyvall, Harry O., Smith Mem. Hosp., Gustine.
Ory, Lee K., Comanche.
Pence, Winfield S., San Saba.
Pope, Fielding M.,
501 Citizens Natl. Bk. Bldg., Brownwood.
Snyder, Ned, Jr., Coggin at 12th, Brownwood.
Spencer, Fred D., Jr.,
308 W. Chandler, Brownwood.
Stephens, Joe B., Bangs.
Walker, James B. N., Brownwood.
Wheelis, Paul M.,
Medical Arts Bldg., Brownwood.

COLEMAN

Aston, S. N., (Hon.), Coleman.
Bailey, Robert, (Hon.), Coleman.
Burke, Francis M., 309 S. Pecos, Coleman.
Jennings, William L., Coleman.
Kemper, R. F., (Sec'y),
Coleman Mutual Bldg., Coleman.
Kollwitz, Fred E., 1400 Fae St., Santa Anna.
Lovelady, Roy R., 309 S. Pecos St., Coleman.
Mann, Morris D., (Pres.),
301 W. Pecan, Coleman.
Moody, Charles O., 301 W. Pecan St., Coleman.
Weaver, Manly E.,
Coleman Co. Bk. Bldg., Coleman.
Yarbrough, Cecil G., 315 W. Elm, Coleman.
Young, Josephus C., 205 W. Elm, Coleman.

CRANE-UPTON-REAGAN

Gossett, James D., Rankin.
Maynard, Billy J., Box 1145, Crane.
Nibling, Boyd, Box 1178, McCamey.
Terry, John E., (Sec'y), Box 1145, Crane.
Wright, John L., Jr., (Pres.),
Box 847, Big Lake.

KIMBLE-MASON-MENARD-McCULLOCH

Anderson, James P., Brady.
Anderson, James S., Brady.
Baze, Perry A., (Hon.), Mason.
Bodenhamer, James G., Mason.
Coffey, H. Franklin, Melvin.
Gardner, James H., Jr.,
P. O. Box 125, Menard.
Hallum, B. A., Jr., Brady.
Hanus, Joseph J.,
Austin State Hosp., Austin.
Hartgraves, Hallie, (Hon.),
Kemper Hall, Kenosha, Wisc.
Hays, Aaron R., (Hon.), Brady.
Hays, Robert D., Brady.
Hinchman, Alda W., Brady.
Johnson, Joel H., (Sec'y), Box 426, Mason.
Jordan, Dowdell W., Brady.
Land, Wm. M., (Hon.), Lohn.
McCall, John G., (Hon.), Brady.
McCulloh, Albert M., (Pres.), Brady.
Ricks, Glenn H., Brady.

RUNNELS

Bailey, Charles F., Ballinger.
Chandler, Oren H., Ballinger.
Dixon, James W., (Hon.), Box 30, Winters.
Downing, Lloyd L., Box 494, Ballinger.
Green, John E., Jr., (Pres.), Ballinger.
Jennings, Thomas V., (Hon.), Winters.
McCreight, Henry H., (Sec'y),
Box R, Winters.
Rives, C. T., Winters.
Shiller, John J., Rowena.

TOM GREEN-COKE-CROCKETT-CONCHO-IRION-STERLING-SUTTON-SCHLEICHER

Alexander, Eugene P.,
2021 W. Beauregard, San Angelo.
Allison, Richard F.,
McKnight State San., Sanatorium.
Anderson, Hiram M.,
224 E. Harris, San Angelo.
Anderson, Wilson D.,
123 W. Harris, San Angelo.
Arledge, Robert M.,
203 E. Harris, San Angelo.
Ballard, John E.,
Shannon Mem. Hosp., San Angelo.
Barry, Douglas J.,
115 E. Beauregard, San Angelo.
Bolen, John G.,
Shannon Mem. Hosp., San Angelo.
Boster, Raymond G.,
219 S. Magdalen, San Angelo.
Brask, H. Kermit, 1411 Shafter, San Angelo.
Brauns, Wilhelm H.,
234 W. Beauregard, San Angelo.
Browne, Charles F., Sonora.
Bunyard, Joseph A.,
S. A. Natl. Bk. Bldg., San Angelo.
Burgess, George A.,
McKnight San., Sanatorium.
Butner, Wendell B.,
201 E. Beauregard, San Angelo.
Byars, Perry J. C., Jr.,
19 S. Park St., San Angelo.
Carter, John E., Eden.
Chase, Ralph R., Jr.,
234 W. Beauregard, San Angelo.
Cohen, Milton R., (Mil.),
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Coleman, T. Gabe,
510 W. Beauregard, San Angelo.
Cornelison, Joe L.,
510 W. Beauregard, San Angelo.
Eckhardt, Gus F.,
510 W. Beauregard, San Angelo.
Engelking, Chas. F.,
234 W. Beauregard, San Angelo.
Everhart, Merrill W.,
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Finks, Robert M., Clinic Hospital, San Angelo.
Franken, Robert,
408 Chadbourne Bldg., San Angelo.
French, Cecil M., 339 W. Harris, San Angelo.
Gainer, Marthalyn J.,
612 E. Parkway, San Angelo.
Gainer, Sam H., (Pres.),
110 S. Magdalen, San Angelo.
Harris, John R., Bronte.
Harris, Orion W., P. O. Box 483, Sanatorium.
Hayter, Dale W.,
234 W. Beauregard, San Angelo.
Hershberger, Lloyd R.,
22 S. Magdalen, San Angelo.
Hickman, H. E.,
123 E. Beauregard, San Angelo.
Hollister, W. L., (Inac.),
202 E. Ave. J, San Angelo.
Hooker, James W.,
510 W. Beauregard, San Angelo.
Howell, John F., Sonora.
Hunter, Darlene L.,
2719 Live Oak, San Angelo.
Hunter, Thos. R., Jr.,
234 W. Beauregard, San Angelo.
Hutchins, F. Leon,
McBurnett Bldg., San Angelo.
Irvine, Geo. N., Jr.,
510 W. Beauregard, San Angelo.
Johnson, Clay H.,
205 E. Beauregard, San Angelo.
Joiner, Bennett A., 111 E. Harris, San Angelo.
Jones, Robert R.,
2015 W. Beauregard, San Angelo.
Kilman, William J.,
McKnight San., Sanatorium.

Knight, Maynard D.,
234 W. Beauregard, San Angelo.
Kunath, Carl A., 111 E. Harris, San Angelo.
Landy, Aaron E., 14 S. Jefferson, San Angelo.
Lewis, Aubrey L.,
123 E. Beauregard, San Angelo.
Lindsey, William H., (Int.),
335 W. Illinois, Dallas.
Martin, Scott H., 115 S. Park, San Angelo.
McCaw, Blanche M.,
110 S. Magdalen St., San Angelo.
McCaw, William H.,
111 E. Harris, San Angelo.
McDaniel, John D., Robert Lee.
McIntire, Floyd T., Box 1472, San Angelo.
McKnight, Joseph B., (Hon.),
2206 Dallas St., San Angelo.
Mee, Edmond L., 224 E. Harris, San Angelo.
Moon, Roy E., 234 W. Beauregard, San Angelo.
Morse, Robert A.,
234 W. Beauregard, San Angelo.
Mowrey, Jack I., Box 548, Eldorado.
Nesrsta, George L., 111 E. Harris, San Angelo.
Nibling, George W., (Hon.),
1416 W. Harris, San Angelo.
Peyton, Alton B., 224 E. Harris, San Angelo.
Pilmer, Gordon A.,
1401 W. Beauregard, San Angelo.
Porter, William L., 111 E. Harris, San Angelo.
Powers, Rufus L., 203 E. Harris, San Angelo.
Rape, J. Marvin, 22 S. Magdalen, San Angelo.
Read, John L.,
2017 W. Beauregard, San Angelo.
Reilly, Daniel R., City Hall, San Angelo.
Ricci, Henry N., 602 S. Abe, San Angelo.
Round, Harry F., 201 E. Harris, San Angelo.
Round, Kye B., 201 E. Harris, San Angelo.
Rush, Clyde E., 19 S. Park, San Angelo.
Schulkey, William E.,
1221 S. Madison, San Angelo.
Schulze, Victor E.,
219 S. Magdalen, San Angelo.
Sessums, J. Valton,
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Sessums, John R., (Hon.),
1324 W. Ave. D, San Angelo.
Simon, Ralph E., Jr., Box 818, Ozona.
Smith, W. Lacey, 111 E. Harris, San Angelo.
Spencer, Francis M., (Sec'y),
111 E. Harris Ave., San Angelo.
Swann, William J., Sterling City.
Tandy, Hugh B., Ozona.
Tester, Lewis K., Central Natl. Bk., San Angelo.
Thompson, Chase S.,
111 E. Harris, San Angelo.
Trotter, Raleigh F.,
9 S. Magdalen, San Angelo.
Wall, D. D., 234 W. Beauregard, San Angelo.
White, James N., 206 E. Harris, San Angelo.
Williams, Harvey M.,
1401 W. Beauregard, San Angelo.
Windham, Robert E., (Hon.),
Christoval Rd., San Angelo.
Winkelmann, Eugene C.,
1606 W. Beauregard, San Angelo.
Wisely, John S., State TB Hosp., Sanatorium.
Womack, Clifford T.,
401 Central Natl., San Angelo.
Womack, William T., (Mil.),
7306 Gerris, S.E., Albuquerque, N. M.
Wood, Marion L., 224 E. Harris, San Angelo.

FIFTH DISTRICT

Dr. Robert F. Gossett, San Antonio, Councilor

ATASCOSA

Austin, John D., (Sec'y), Pleasanton.
Day, Ancie Fred, Jr., P. O. Box 357, Runge.
Faggard, John M., Poteet.
Joyce, Walter H., Lytle.
Logan, Ben Merl, Box 306, Jourdanton.
Mann, Robert E., P. O. Box 538, Pleasanton.
Morron, Clyde R., George West.
Ogden, U. B., (Pres.), Box 568, Pleasanton.
Parker, Milton F., P. O. Box 306, Jourdanton.
Ward, Jeremiah, (Hon.), Poteet.
Ware, Thomas P., (Hon.), Poteet.

BEXAR

Adelman, Jack A.,
505 Moore Bldg., San Antonio.
Aderhold, James P.,
1116 Med. Arts Bldg., San Antonio.
Adler, Harry F.,
274 W. Ware Blvd., San Antonio.
Adlof, Carolyn M., (Int.),
Baylor Univ. Hosp., Dallas.
Albert, Arnold, 2714 S. Presa St., San Antonio.
Albert, Monroe, 2714 S. Presa St., San Antonio.
Alexander, Charles B.,
1716 Nix Prof. Bldg., San Antonio.
Allen, Sovern W.,
1020 Med. Arts Bldg., San Antonio.
Allin, Frederick A., (Hon.),
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Allin, Willis W.,
1109 E. Commerce, San Antonio.
Altgelt, Daniel D.,
219 W. Gramercy, San Antonio.
Altgelt, James E.,
1018 S. Texas Bldg., San Antonio.
Alvelais, Guillermo R.,
318 N. Santa Rosa, San Antonio.
Alvis, Milton E.,
422 Med. Arts Bldg., San Antonio.
Arendt, Erich J.,
412 W. Mistletoe, San Antonio.
Atkinson, Basil E., Jr., (Int.),
759 Edgebrook Lane, San Antonio.
Atkinson, Donald T.,
827 Med. Arts Bldg., San Antonio.
Atmar, Robert C.,
205 Camden St., San Antonio.
Barnett, John L.,
1206 Nix Prof. Bldg., San Antonio.
Baros, James A., 807 Gibbs Bldg., San Antonio.
Barton, Julian C.,
909 Nix Prof. Bldg., San Antonio.
Bates, Leroy E.,
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Bates, Leroy E., Jr., (Int.),
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Beal, Albert R., (Dead),
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Beck, Emma, (Inac.), Fredericksburg.
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Berchelmann, David A.,
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Bernard, George E.,
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Berry, Joe H., 516 Lexington, San Antonio.
Berry, Lloyd E., Jr., 605 Belknap, San Antonio.
Biggar, James H., (Hon.),
242 Rockwood St., San Antonio.
Bishop, Elmer W.,
1911 Pleasanton Rd., San Antonio.
Blair, James R., Jr.,
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Block, William J.,
1111 Nix Prof. Bldg., San Antonio.
Bloom, Bernard H.,
629 Moore Bldg., San Antonio.
Blumer, Max A.,
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Boccelato, Salvador L.,
3304 W. Commerce, San Antonio.
Boehs, Charles J.,
1119 Med. Arts Bldg., San Antonio.
Bohmfalk, John H.,
227 E. Hildebrand, San Antonio.
Bondurant, William W., Jr.,
811 Nix Prof. Bldg., San Antonio.
Bonnet, Edith M.,
228 Med. Arts Bldg., San Antonio.
Borsheim, Raymond S.,
1702 Nix Prof. Bldg., San Antonio.
Bosshardt, Carl E., 145 Hillview, San Antonio.
Botkin, Rolan R., 3721 S. Presa, San Antonio.
Bowen, Robert E., Jr., (Mil.), San Antonio.
Bowen, Robert E., Sr., (Inac.),
1849 W. Gramercy, San Antonio.
Boyd, G. D., 1411 N. Main St., San Antonio.
Boysen, Arthur E.,
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Bradley, Roy W.,
1128 Nix Prof. Bldg., San Antonio.
Breath, Marshall B.,
124 Dallas St., San Antonio.
Brendel, William B.,
111 Gen. Krueger, San Antonio.
Breuer, Alfred, 525 Richmond, San Antonio.
Brewer, Dorothy, 124 Dallas St., San Antonio.
Britton, Howard A.,
402 Fulton Ave., San Antonio.
Brown, Alexander A., (Hon.),
233 Linda Dr., San Antonio.
Brown, Charles T.,
832 Med. Arts Bldg., San Antonio.
Brunner, G. Harmon,
1208 S. Texas Bldg., San Antonio.
Brunner, Robbie Neeley,
1208 S. Texas Bldg., San Antonio.
Burg, Edward M.,
805 Maverick Bldg., San Antonio.
Burk, Joseph E.,
3203 San Pedro, San Antonio.
Burk, William E.,
1030 Med. Arts Bldg., San Antonio.
Burkhardt, William L.,
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Burleson, John H., (Emer.),
644 Funston, San Antonio.
Burns, Thomas B.,
1717 Nix Prof. Bldg., San Antonio.
Burton, Kenneth G.,
3506 S. New Braunfels, San Antonio.
Bush, Howard M.,
1629 Nix Prof. Bldg., San Antonio.
Buttery, Harold D.,
1031 Nix Prof. Bldg., San Antonio.
Buttery, James M.,
609 Med. Arts Bldg., San Antonio.
Calder, Royall M.,
Medical Arts Bldg., San Antonio.
Callan, John R.,
110 E. Hermosa Dr., San Antonio.
Calvert, Hulon E.,
506 Med. Arts Bldg., San Antonio.
Campbell, Billy Gay,
3721 S. Presa St., San Antonio.
Carter, James W., Jr.,
818 Nix Prof. Bldg., San Antonio.
Case, John B.,
625 Med. Arts Bldg., San Antonio.
Castle, Margaret R.,
545 New Moore Bldg., San Antonio.
Cayo, Edward A.,
923 Med. Arts Bldg., San Antonio.
Cayo, Ernest P., (Inac.),
Med. Arts Bldg., San Antonio.
Celaya, Albert, 124 Dallas St., San Antonio.
Celaya, Henry,
1211 Med. Arts Bldg., San Antonio.
Center, William M.,
605 Belknap, San Antonio.
Champion, Albert N.,
1223 Med. Arts Bldg., San Antonio.
Chandler, Jack R.,
915 Med. Arts Bldg., San Antonio.
Chankin, Edgar D.,
525 Richmond, San Antonio.
Childers, Herschel N.,
5148 Broadway Ave., San Antonio.
Childers, Marvin A.,
Alamo Natl. Bk. Bldg., San Antonio.
Christian, Thomas E.,
810 Med. Arts Bldg., San Antonio.
Clark, A. Fletcher, Jr.,
225 Med. Arts Bldg., San Antonio.
Clark, A. Fletcher, Sr.,
225 Med. Arts Bldg., San Antonio.
Clifton, Collis B.,
303 Maverick Bldg., San Antonio.
Coates, Elmer T.,
401 W. Summit, San Antonio.
Cochran, J. Layton,
1220 Med. Arts Bldg., San Antonio.
Coffman, Graham M.,
625 Med. Arts Bldg., San Antonio.
Collins, George P., (Mil.),
3810th USAF Hosp., Maxwell AFB, Ala.
Collins, Vera L.,
145 Parland Pl., San Antonio.
Conroy, Normabelle H.,
307 Wyndale, San Antonio.
Cook, Clara G.,
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Cook, James T., (Int.),
518 Avalon, San Antonio.
Cook, Walter R.,
123 Ogden Lane, San Antonio.
Cooper, Elmer E.,
505 Howard, San Antonio.
Cooper, Fred B., 2001 N. Main, San Antonio.
Cooper, Harold N.,
212 W. Laurel, San Antonio.
Cooper, Jean Head,
211 Richmond Ave., San Antonio.
Cooper, Melbourne J.,
211 Richmond Ave., San Antonio.
Copeland, Joseph B., (Pres.),
1014 Med. Arts Bldg., San Antonio.
Cotham, Christian M.,
414 Med. Arts Bldg., San Antonio.
Couch, Marshall D.,
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Cover, Ellen C.,
S. A. State Hosp., San Antonio.
Cowles, Andrew G., (Hon.),
202 W. Kings Hwy., San Antonio.
Coyle, Edward W.,
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Creamer, Dick O.,
817 S. Texas Bldg., San Antonio.
Cresswell, Thomas A., (Int.),
486 Cherry Ridge, San Antonio.
Crews, Eli Rush,
339 Elizabeth Rd., San Antonio.

Curtis, Margaret S.,
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Dalkowitz, Marcus B.,
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Davis, David F.,
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Davis, F. Milton,
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Davis, Herman L.,
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Davis, J. Walker,
531 Med. Arts Bldg., San Antonio.
Davis, Roy N.,
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Day, Phillip L.,
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DeGasperi, Joseph A.,
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Des Rochers, Jean B.,
S. A. State TB. Hosp., San Antonio.
Diseker, Thomas H.,
328 Med. Arts Bldg., San Antonio.
Dittman, Charles H.,
411 Med. Arts Bldg., San Antonio.
Dodge, Donald T.,
1216 S. Texas Bldg., San Antonio.
Donaldson, James M., Jr.,
923 Nix Bldg., San Antonio.
Dones, Henry C.,
1212 Med. Arts Bldg., San Antonio.
Donop, Perry T.,
2020 Alamo Natl. Bk., San Antonio.
Dorbandt, Moss M.,
128 W. Commerce St., San Antonio.
Doyle, John L., (Int.),
443 Future Dr., San Antonio.
Dreibrodt, Ben A.,
612 New Moore Bldg., San Antonio.
Dreiss, Adolph M.,
319 Mission St., San Antonio.
Dufner, Romie M.,
3721 S. Presa St., San Antonio.
Dumas, Edward D.,
425 Med. Arts Bldg., San Antonio.
Duncan, Everett T.,
1009 S. Texas Bldg., San Antonio.
Dupre, Joseph R.,
2331 Vance Jackson, San Antonio.
Ellington, Jesse C.,
128 W. Commerce St., San Antonio.
Ellis, Sam, 710 Med. Arts Bldg., San Antonio.
Elmendorf, Hugo F., Jr.,
730 Med. Arts Bldg., San Antonio.
Estrada, Felipe, Nix Prof. Bldg., San Antonio.
Estrada, Ramiro P.,
318 N. Santa Rosa, San Antonio.
Fairweather, M. Jeanne, (Int.),
Robt. B. Green Hosp., San Antonio.
Farrell, Elnora Anne,
2819 N. McCullough, San Antonio.
Fein, Bernard T.,
1422 Nix Prof. Bldg., San Antonio.
Ferrero, James J.,
205 Camden St., San Antonio.
Fetzer, William J.,
1530 W. Summit, San Antonio.
Finney, James W.,
200 Donaldson, San Antonio.
Finsterwald, James F.,
119 Gen. Krueger, San Antonio.
Fischer, Albert,
618 Moore Bldg., San Antonio.
Fisher, Rowan E., Nix Bldg., San Antonio.
Folbre, Thomas W.,
1219 Nix Prof. Bldg., San Antonio.
Franke, Winthrop I.,
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French, Jack A.,
906 Fredericksburg, San Antonio.
Galindo, Desiderio L.,
515 Morales St., San Antonio.
Galloway, Ballard E.,
306 Houston Bldg., San Antonio.
Garnett, Walter L.,
Paseo Reforma 510, Mexico 6 D. F., Mex.
Garza, Remberto, (Int.),
129 Jeffrey, San Antonio.
Geissler, Wallace H.,
Nix Prof. Bldg., San Antonio.
Gerodetti, Orlando F.,
344 Mary Louise Dr., San Antonio.
Giesecke, Carl G., (Mil.), San Antonio.
Glass, Thomas G., Jr., (Int.),
Robt. B. Green Hosp., San Antonio.
Goeth, Carl F., 810 Gibbs Bldg., San Antonio.
Goeth, Richard A., (Hon.),
809 Gibbs Bldg., San Antonio.
Goldzieher, Joseph W.,
1133 Med. Arts Bldg., San Antonio.
Gonzalez, Hesiquio N.,
318 N. Santa Rosa, San Antonio.
Gonzalez, Joaquin B.,
318 N. Santa Rosa, San Antonio.
Goode, John W., 205 Camden St., San Antonio.
Goodnight, James E.,
1005 Nix Prof. Bldg., San Antonio.
Goodpasture, John E.,
2407 W. Huisache, San Antonio.
Gootee, Hubert George,
2714 S. Presa St., San Antonio.
Gordon, Marie D.,
205 Camden St., San Antonio.
Gordon, Wm. H., Jr.,
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Gorsuch, Paul L.,
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Gossett, Robert F.,
205 Camden St., San Antonio.
Grant, Harold,
602 W. French Pl., San Antonio.
Graves, William E.,
1717 Nix Prof. Bldg., San Antonio.
Gray, Arthur M., 119 Burkedale, San Antonio.
Greer, Sam J., Jr.,
823 Nix Prof. Bldg., San Antonio.
Gregory, Ernest J., Jr.,
809 Nix Prof. Bldg., San Antonio.
Griffin, Robert W.,
Nix Prof. Bldg., San Antonio.
Griswold, James A.,
3506 S. New Braunfels, San Antonio.
Haggard, Charles H.,
1228 Med. Arts Bldg., San Antonio.
Haggard, Frank N.,
1228 Med. Arts Bldg., San Antonio.
Haley, Robert Roscoe,
216 N. Santa Rosa, San Antonio.
Hardy, Robert C.,
1233 Nix Prof. Bldg., San Antonio.
Hargis, W. Huard, Sr.,
205 Camden St., San Antonio.
Harle, Raymond P., (Int.),
551 W. Hermosa, San Antonio.
Hartman, Albert W., Jr.,
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Hartman, Henry C., (Hon.),
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258 E. Main St., Fredericksburg.
Thorne, Frederic H. (Hon.),
1623 E. Pyron Rd., San Antonio.
Wiedeman, John E., Junction.

LaSALLE-FRIO-DIMMIT

Barnard, W. L. (Hon.), Carrizo Springs.
Brown, Dorothy V. M., Box 53, Catarina.
Crawford, John M., Carrizo Springs.
Lindley, Calvin D. (Hon.), Carrizo Springs.
McKinley, Robert L. (Mil.), Pearsall.
Myers, Clyde P., Cotulla.
O'Connor, Timothy D., Pearsall.
Pickett, Jack B. E. Jr.,
Box 398, Carrizo Springs.
Pickett, B. E. Sr., Carrizo Springs.

Primomo, John S. (Pres.), Dilley.
Primomo, Marion P. (Sec'y), Dilley.
Wilson, Emmett N. Jr., Box 696, Pearsall.
Wilson, Wm. S. Jr.,
498 Clark St., Carrizo Springs.

MEDINA-UVALDE-MAVERICK-VAL VERDE
EDWARDS-REAL-KINNEY-
TERRELL-ZAVALA

Allison, George M., 126 W. Nopal St., Uvalde.
Brittain, Mary Ruth,
204 E. Zavala, Crystal City.
Burditt, Bucky L., 901 Griner, Del Rio.
Calderon, Fermin, 838 S. Main St., Del Rio.
Cartall, Louis M., 300 Dignowity St., Del Rio.
Crossley, S. W. (Hon.), Del Rio.
Cunningham, George B., Uvalde.
Dimmitt, Dean P., Uvalde.
Donaldson, Elizabeth, Ross Bldg., Del Rio.
Eads, Ray A., Uvalde.
Eckert, Robert R.,
Castroville Hosp. and Clinic, Castroville.
Folsom, Charles W., Box 311, Brackettville.
Fly, Sterling H. Jr., 105 N. Piper Lane, Uvalde.
Gates, Ellis F., 577 Ceylon, Eagle Pass.
Graham, Robert N., Del Rio.
Herrmann, George H.,
301 Del Rio Bank Bldg, Del Rio.
Howard, Woods A. (Int.),
Watson Clinic, Lakeland, Fla.
Hyslop, James R., Ross Drug Co., Del Rio.
Kaback, Harry, 421 Washington St., Eagle Pass
LaForge, Hershall, Uvalde.
Lewis, B. Oliver (Pres.),
P. O. Box K, Eagle Pass.
McWilliams, William R., Del Rio.
Meredith, William P., Del Rio.
Merritt, George H. (Hon.),
Rocksprings Road, Uvalde.
Meyer, Walter B., Hondo.
Mims, Joe M., 1115 17th St., Hondo.
Montemayor, Raul M.,
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Peters, Leo E., Devine.
Poindexter, Cary A., Crystal City.
Pratt, Frank H., Rocksprings.
Rankin, Richard C. Jr.,
121 W. South St., Uvalde.
Rodriguez, Simon, Del Rio.
Samsel, Theodore B. Jr. (Sec'y),
217 N. 1st Ave., Crystal City.
Spencer, John C., 212 Maverick, Crystal City.
Wurzbach, Fay, Castroville.

SIXTH DISTRICT

Dr. F. W. Yeager, Corpus Christi, Councilor

BEE-LIVE OAK-McMULLEN

Edmondson, John W.,
908 N. St Marys, Beeville.
Kirkland, Luman W.,
310 N. St Marys, Beeville.
Lancaster, Howard E., (Sec'y.),
Box 559, Beeville.
McNeill, Scott E., Beeville.
Miller, Ernest E., Beeville.
Muecke, Elmo W., Three Rivers.
Poff, Claude M., (Inac.), Tuleta.
Reagan, James L., (Pres.),
310 N. Washington, Beeville.
Reagan, John W., 908 N. St Marys, Beeville.
Reagan, Tom B., Beeville.
Sansom, George W., George West.

BROOKS-DUVAL-JIM WELLS

Albert, Richard O., (Sec'y.),
64 N. Wright St., Alice.
Allison, Albert M., 1031 E. Main St., Alice.
Buck, Haldor R., Premont.
Davis, Glenn B., Box 576, Falfurrias.
Glendenning, F. C., Hebbronville.
Gonzalez, Juan C., Benavides.
Haag, Edmund L., Jr., Freer.
Hocott, Joseph F., Freer.
Howard, Glenn T., Box 1277, Alice.
Joseph, Philip S., Alice.
Moet, John Allen, Orange Grove.
Moore, Victor, Premont.
Newkirk, William H., 1031 E. Main St., Alice.
O'Neil, Andrew W., Falfurrias.
Penly, Richard S., Falfurrias.
Riddle, Riley N., 70 N Wright St., Alice.
Virgin, Edwin P., 501 N. Reynolds, Alice.
Wallace, Virgle W.,
318 N. Jackson, San Angelo.
Wilder, Lowell E., Falfurrias.
Williams, J. Harold, (Pres.), Alice.
Wyche, Geo. G., Jr., 310 N. Wright St., Alice.
Wyche, Geo. G., Sr., 310 N. Wright St., Alice.

CAMERON-WILLACY

Allen, George Earl, (Mil.), Harlingen.
Amidon, Vivien M.,
McKelvey Bldg., Harlingen.
Ashcraft, E. Jeff., Jr.,
613 W. Filmore, Harlingen.
Atchison, Martin V.,
1622 Ed Carey Dr., Harlingen.
Baden, Ervin E., 152 S. 6th St., Raymondville.
Baden, Wayne F.,
Medical Arts Bldg., Raymondville.
Beazley, H. Liston, Box 1046, Harlingen.
Bedri, Marcel R.,
501 McKelvey Bldg., Harlingen.
Benavides, Simon I., Jr., Raymondville.
Bennack, George E.,
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Berrey, Bedford H., (Mil.),
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Binney, Charles, II, Box 1509, Harlingen.
Bleakney, Phil A., 214 E. Harrison, Harlingen.
Bowyer, Charles H.,
P. O. Box 535, Los Fresnos.
Breeden, Roy F.,
105 W. Elizabeth, Brownsville.
Breyer, Amy, 105 W. Elizabeth, Brownsville.
Brown, John F., Jr.,
315 N. Sam Houston, San Benito.
Caldeira, Frederick D.,
113 W. Van Buren, Harlingen.
Calderoni, Francisco F.,
37 W. Elizabeth, Brownsville.
Cannon, George M.,
48 W. Levee St., Brownsville.
Carranza, Enrique M., Brownsville.
Casey, James D.,
400 W. Highway 77, San Benito.
Cash, Clarence M., (Hon.),
1040 N. Bowie, San Benito.
Chase, Ned B., Jr., (Mil.), San Benito.
Childress, James L.,
1710 Ed Carey Dr., Harlingen.
Clarke, James Y., 212 E Harrison, Harlingen.
Cope, Solomon F., 1120 Garcia, Port Isabel.
Cowgill, David M.,
1135 N. Sam Houston, San Benito.
Davis, Lum M., Embee Bldg., Harlingen.
De La Garza, Enrique, Box 2042, Brownsville.
Destefano, Frederick W.,
55 W. Elizabeth, Brownsville.
Dieck, John A., 211 E. Harrison, Harlingen.
Duncan, George W.,
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Dyo, Kaoru, 324 E. Harrison St., Harlingen.
Eckley, Robert, 33 E. Elizabeth, Brownsville.
Eisaman, Ralph H.,
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Englerth, Fred L., 306 S. 3rd St., Harlingen.
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Gallaher, George L.,
McKelvey Bldg., Harlingen.
George, James C., II,
705 W. Jefferson, Brownsville.
Goerger, Verne F.,
665 W. Riggs, Raymondville.
Guerrero, Emilio,
1049 E. Washington, Brownsville.
Haas, Nelson W.,
380 N. Sam Houston, San Benito.
Hamilton, Oscar A., 310 S. 3rd St., Harlingen.
Harren, Henry F., Jr., (Mil.), San Benito.
Harrop, L. Louis,
322 E. Monroe Ave., Harlingen.
Hartman, John T.,
1616 Ed Carey Dr., Harlingen.
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Hawkins, W. W.,
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Heins, Otto H., Raymondville.
Higgs, Paul C.,
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Keeble, Leon, Jr.,
525 Villa Maria Blvd, Brownsville.
Kinder, Thurman A., Jr.,
248 E. Levee St., Brownsville.
Krishna, Ikbal.
47 W. Elizabeth St., Brownsville.
Kruisheer, H. E. J., Harlingen.
Kuppinger, John C., (Sec'y.),
613 W. Filmore, Harlingen.
Lamm, Annie T., La Feria.
Lamm, Heinrich, La Feria.
LaMotte, Thomas J.,
613 W. Filmore, Harlingen.
Lancaster, David D.,
501 W. McKinley St., Harlingen.
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Longoria, Vidal, 800 E. Adams, Brownsville.
Loyd, Edward M.,
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Lyle, Charles F., Box 996, San Benito.
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24 S. E. St Charles, Brownsville.
Merrill, Samuel J.,
105 W. Elizabeth, Brownsville.
Miller, Harry Allen, Jr.,
301 E. Washington, Brownsville.
Miller, John B.,
301 E. Washington, Brownsville.
Moet, Joe Louis, LaFeria.
Nickell, David F.,
322 E. Harrison, Harlingen.
Noell, L. Pope, Jr.,
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Olcott, Cornelius, Jr.,
218 E. Harrison, Harlingen.
Packard, John P., 214 E Harrison, Harlingen.
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315 N. Sam Houston, San Benito.
Roth, Karl A., 105 W Elizabeth, Brownsville.
Salinger, Leland M.,
105 W. Elizabeth, Brownsville.
Scales, Hunter L., Jr.,
375 N. Sam Houston, San Benito.
Scanlan, Nestor, 450 W Jefferson, Brownsville.
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Works, Lee, 105 W. Elizabeth, Brownsville.
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HIDALGO-STARR

Allen, Francis A., 112 E. 11th, Mission.
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Dick, Delfred L., 225 W Park, Pharr.
Duncan, Wallace H., McAllen.
Edwards, Thomas G., 301 Texas, Mercedes.
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Fry, Wilburn S., Jr., (Mil.),
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Garcia, Raul, 620 S. Broadway, McAllen.
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Graham, Ronald A., Pharr.
Greene, Maurice L.,
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Guerra, Lauro G., 701 S. 16th St., McAllen.
Hamme, Curtis J., (Hon.), (Dead),
505 S. Closner, Edinburg.
Hamme, Ralph E., 505 S. Closner, Edinburg.
Hatfield, Walter H., McAllen.
Heidrick, Daniel L., 446 Texas Ave., Mercedes.
Hoffmaster, Vance D.,
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Kellar, Robert J., Weslaco.
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Martin, James C., Jr., Mission.
Matthews, John W., 509 S. Closner, Edinburg.
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Parker, Samuel T., (Hon.), Pharr.
Pence, Roy W., (Hon.),
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Prof. Arts Bldg., McAllen.
Rabinowitz, Haskell I., 817 Quince, McAllen.
Ramirez, Mario E., (Mil.), Roma.
Reed, Walter Earl, San Juan.
Riley, Pat 213 E. 10th St., Mission.
Rodriguez, M. J.,
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Sanchez, Santiago A.,
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Terrell, Pruitt D., (Sec'y.),
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Trevino, Jorge H., 718 S. Main St., McAllen.
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Westphal, Herbert M., Weslaco.
Wharton, James O., (Dead), McAllen.
Whigham, Herschel E., 412 S. Main, McAllen.
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KLEBERG-KENEDY

Barnett, Lawrence M., Bishop.
Boyd, Newell D.,
227 W. Kleberg St., Kingsville.
Dunn, S. Chester, 831 Alexander, Kingsville.
Ewert, William A.,
704 E. Ceasar St., Kingsville.
Gaston, Earl, 722 E. Ragland St., Kingsville.
Ginther, Clarke E., Bishop.
Grief, Emmett W.,
613 E. Ragland St., Kingsville.
Higgins, Frank B.,
230 W. Yoakum St., Kingsville.
Jones, A. C., 730 W. Lee St., Kingsville.
Lambeth, Charles B. (Sec'y),
1202 Circle Dr., S., Kingsville.
Peace, Dewey W., Bishop.
Peace, Dewey W., Jr., Bishop.
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Scales, James R.,
227 W. Kleberg St., Kingsville.
Sublett, Collier M. (Pres.),
723 W. Lee St., Kingsville.
Walling, Bert H., Jr.,
227 W. Kleberg St., Kingsville.
Wiles, William T. (Hon.), Riviera.

NUECES

Abbey, Joseph A.,
2451 Morgan, Corpus Christi.
Ahern, Gerald S.,
1017 Santa Fe, Corpus Christi.
Alsop, Joseph F.,
237 Med.-Dental Bldg., Corpus Christi.
Anderson, William E.,
1001 Louisiana, Corpus Christi.
Appel, Myron H.,
1200 Santa Fe, Corpus Christi.
Arnim, Landon C.,
2424 Morgan, Corpus Christi.
Ashmore, Alvin J.,
225 Med.-Dental Bldg., Corpus Christi.
Barnard, James L. (Pres.),
1240 3rd St., Corpus Christi.
Barnard, Wm. C.,
1240 3rd St., Corpus Christi.
Barnes, George B.,
2400 Morgan Ave., Corpus Christi.
Bernwanger, Damon C.,
2935 Norton, Corpus Christi.
Bickley, Estill T., 2524 Morgan, Corpus Christi.
Blaine, Alva L., 2466 Morgan, Corpus Christi.
Blaine, Mose H., Jr.,
2466 Morgan, Corpus Christi.
Blair, John V.,
308 Wilson Bldg., Corpus Christi.
Bounds, Lloyd D.,
15 Med. Center, Corpus Christi.
Brown, Walter C.,
1733 S. Brownlee Blvd., Corpus Christi.
Bryson, J. Gordon, Jr.,
1209 Santa Fe, Corpus Christi.
Burns, Herbert V.,
1326 Santa Fe, Corpus Christi.
Cameron, Ralph H., Jr.,
2433 Morgan, Corpus Christi.
Carlson, O. Sherman,
1755 Santa Fe, Corpus Christi.
Carr, Robert H., 527 Gordon, Corpus Christi.
Chriss, John W.,
2436 Morgan St., Corpus Christi.
Clark, Chas. S.,
233 Med.-Dental Bldg., Corpus Christi.
Clark, Dan H., 1001 Louisiana, Corpus Christi.
Cline, William B., Jr.,
2471 Morgan, Corpus Christi.
Coleman, Sherman T.,
1001 Louisiana, Corpus Christi.
Collins, C. B. (Hon.),
338 Louise, Corpus Christi.
Colyer, George E.,
1001 Louisiana, Corpus Christi.
Concklin, Charles L.,
P. O. Box 3475, Corpus Christi.
Conolly, Sidney M.,
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Crain, Carroll F.,
1214 Santa Fe, Corpus Christi.
Danford, Edwin A., 712 Booty, Corpus Christi.
Davis, Walter T.,
517 Clifford St., Corpus Christi.
Delaney, John J.,
1546 S. Brownlee, Corpus Christi.
Dixon, Chalmer D.,
205 Wilson Bldg., Corpus Christi.
Dolch, Stanley F. N., Jr.,
4206 Ayers St., Corpus Christi.
Draper, Leonidas M.,
207 Wilson Bldg., Corpus Christi.
Eberle, Howard J.,
202 Med.-Dental Bldg., Corpus Christi.
Eckhardt, Kleberg,
3832 Denver, Corpus Christi.
Edwards, Thos. W.,
244 Oleander St., Corpus Christi.
Ellis, Frank A. (Inac.),
611 Blucher, Corpus Christi.
Etheridge, John M.,
1611 Fifth St., Corpus Christi.
Feerer, Donald J., 521 Clifford, Corpus Christi.
Fitzgerald, Thomas F.,
1001 Louisiana, Corpus Christi.
Frank, Thelma E.,
129 Rainbow Lane, Corpus Christi.
Fraser, David B., 1611 5th St., Corpus Christi.
Frich, Michael C.,
525 Everhart Rd., Corpus Christi.
Friedman, Bernard B.,
916 Jones Bldg., Corpus Christi.
Furman, McIver, Furman Bldg., Corpus Christi.
Gabbard, James G.,
1001 Louisiana, Corpus Christi.
Gaddis, Herman W.,
Gonzales Warm Springs Foun., Gonzales.
Garcia, Clotilde P.,
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Garcia, Hector P.,
3024 Morgan, Corpus Christi.
Garcia, Jose A., 1101 19th St., Corpus Christi.
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Glanz, Sanford, 2435 Morgan, Corpus Christi.
Goodman, Paul H.,
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Gray, Paul M., 2420 Morgan, Corpus Christi.
Griffin, Harold E.,
308 Med. Arts Bldg., Corpus Christi.
Groner, Edwin Ben,
533 Gordon, Corpus Christi.
Grossman, Bernard B.,
1001 Louisiana, Corpus Christi.
Grossman, David N.,
Commerce Bldg., Corpus Christi.
Grossman, Maurice S.,
2425 Morgan, Corpus Christi.
Grossman, Saul, 2530 Morgan, Corpus Christi.
Guttman, L. Paul,
1626 10th St., Corpus Christi.
Guttman, Paul B.,
1626 10th St., Corpus Christi.
Gwin, H. Shannon B.,
407 Med. Arts Bldg., Corpus Christi.
Hamilton, Doyne B., Robstown.
Hartwick, Fred W.,
1222 S. Staples, Corpus Christi.
Haynes, Henry M., Jr.,
2418 Morgan, Corpus Christi.
Heaney, H. Gordon,
1300 3rd St., Corpus Christi.
Heaney, Kathryn,
2709 Swantner, Corpus Christi.
Heymann, Hans E.,
2709 Swantner Dr., Corpus Christi.
Hoffpauir, Alvin C.,
Med. Prof. Bldg., Corpus Christi.
Holt, Everett L.,
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House, Rex C., 2455 Morgan, Corpus Christi.
Howze, Jo W. (Mil.), Robstown.
Hubler, Winthrope R.,
1510 S. Brownlee, Corpus Christi.
Hudson, George C.,
1630 S. Brownlee, Corpus Christi.
Hudson, Richard L.,
531 Gordon, Corpus Christi.
Hyder, Prentiss L.,
2429 Morgan St., Corpus Christi.
Janssen, L. W. O., Jr.,
2444 Morgan, Corpus Christi.
Jasperson, Clarence P.,
1326 Santa Fe, Corpus Christi.
Jimenez, Prospero, Jr.,
2554 Morgan, Corpus Christi.
Johnson, Robert W.,
1209 Santa Fe, Corpus Christi.
Jones, John M., 2514 Morgan, Corpus Christi.
Juarez, Reyna Guillermo,
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Kendrick, Michael C.,
2437 Morgan, Corpus Christi.
Kennedy, Hugh A.,
204 Med.-Dental Bldg., Corpus Christi.
Kiel, Alois F.,
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Mann, Nathan,
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Gardner, Thomas L. (Sec'y), Livingston.
Grimes, Ivison, Camden.
Kurth, Robert L., Livingston.
Olive, Roy A., Box 1172, Austin.
Singleton, Paul C. A. (Pres.), Corrigan.

WALKER-MADISON-TRINITY

Addison, Eugene M. (Sec'y), Huntsville.
Autrey, Stacy L., Trinity.
Barnes, Sam R., Trinity.
Black, F. Ray, 1312 Eleventh St., Huntsville.

Bush, Leonard E. (Pres.),
Box 328, Huntsville.
Cole, Thomas C., 1203 Avenue J, Huntsville.
Cook, John R., Box 32, Trinity.
Goodrich, William A., Sr., Huntsville.
Hanson, Minter D., Huntsville.
Heath, Jesse B., Madisonville.
McKay, James A., Madisonville.
Reed, James E., Jr.,
603 S. Madison, Madisonville.
Steeg, Galen E., Groveton.
Thornton, Harold H., Trinity.
Veazey, William B.,
1203 Avenue J, Huntsville.
Woodward, W. Mac, Huntsville.

WASHINGTON-BURLESON

Dodd, Tilman E., 3303 Hillview Rd., Austin.
Giddings, Thomas H.,
604 Stone St., Brenham.
Hasskarl, Robert A. (Pres.),
Box 696, Brenham.
Hasskarl, Walter F., Sr., Brenham.
Hasskarl, Walter F., Jr., Brenham.
Hodde, Fred H., Box 601, Brenham.
Hodde, Herman O., Brenham.
Knolle, Roger E., Brenham.
Knolle, Waldo A., Brenham.
Pazdral, George V., Somerville.
Railsback, George D., Jr., Caldwell.
Schoenvogel, Clarence W., Brenham.
Schoenvogel, Otto F.,
Schoenvogel Clinic, Brenham.
Schoenvogel, Robert L.,
Citizens Pharmacy Bldg., Brenham.
Siptak, John E., Caldwell.
Smith, Joe C., Caldwell.
Southern, Charles E. (Sec'y), Brenham.
Steinbach, Herbert L., Brenham.
Tottenham, Edwin P.,
106 W. Vulcan St., Brenham.

TENTH DISTRICT

Dr. Stephen B. Tucker, Nacogdoches, Councilor

ANGELINA

Arnett, Robert K., 302 N. Raguet, Lufkin.
Brashear, Doyle H., 919 Ellis Ave., Lufkin.
Clement, J. Carroll, 110 S. Raguet, Lufkin.
Clements, Peyton C., 402 S. First, Lufkin.
Connell, Anna Beth (Sec'y),
P. O. Box 395, Lufkin.
Denman, Byford H., 221 S. First St., Lufkin.
Denman, Linwood H., Box 354, Lufkin.
Evans, Charles W. Jr., 923 Ellis Ave., Lufkin.
Hyman, Bernard, Box 176, Lufkin.
Klein, James C., 110 S. Raguet, Lufkin.
Koch, John C. (Int.),
4511 Paris Ave., New Orleans, La.
Martin, Juan E., 923 Ellis, Lufkin.
McVicker, Bobby H., Box 1076, Lufkin.
Medford, U. Gail, 110 S. Raguet St., Lufkin.
Mitchell, William A.,
201 Hemenway Bldg., Lufkin.
Orman, Forrest C., 302 N. Raguet St., Lufkin.
Peebles, Felix Jr., 419 Perry Bldg., Lufkin.
Pruitt, George Jack, Memorial Hosp., Lufkin.
Shepard, Groom S., 923 Ellis Ave., Lufkin.
Spivey, Dan (Pres.), Box 397, Lufkin.
Stevenson, Stanley L.,
Village Hospital Clinic, Diboll.
Taylor, Robert W., 118½ S. First, Lufkin.
Thames, William D. Jr.,
818 Frank Ave., Lufkin.
Tinkle, Lassiter T., 1608 S. First St., Lufkin.
Wade, Jack H., Box 1300, Lufkin.

HARDIN-TYLER

Barclay, Watt, Woodville.
Burton, L. Gayle, Box 788, Woodville.
Copeland, Sam P. Jr., 735 N. Fifth, Silsbee.
Gauntt, Eugenia T. (Pres.), Kountze.
Gilchrist, John Q., Woodville.
Hooks, Henry A., Kountze.
Parker,Wade M., 735 N. 5th, Silsbee.
Poshataske, Wallace J., 510 N. Fifth St., Silsbee
Ryan, Robert L., 821 Barkley St., Sour Lake.
Spidle, James L., Kountze.
Swearingen, Robt. E., Box 608, Woodville.
Tate, John H., Kountze Clinic, Kountze.
Tate, Robert A., Kountze.
Tennison, George D. (Sec'y),
440 Roosevelt Dr., Silsbee.

JASPER-NEWTON

Dickerson, Joe W., Jasper.
Hall, Henry S. (Hon.), Newton.
Harris, Oscar T. Jr. (Sec'y), Pineland.
Henderson, John A. (Int.),
Hermann Hosp., Houston.
Jones, Thomas R., 139 W. Lamar, Jasper.
Lloyd, R. S., Box 1098, Austin.
Love, Albert J., Newton.
McCreight, William F. (Hon.),
P. O. Box 218, Kirbyville.
McGrath, J. J. (Pres.), Jasper.
Moore, John T., 200 E. Lavielle, Kirbyville.
Richardson, A. J. Jr., Jasper.
Stockdale, Rider E.,
Hardy Hancock Hosp., Jasper.
Winslow, Grover C.,
Hemphill Clinic, Hemphill.

JEFFERSON

Adams, Barnette E. J., Jr.,
1950 Ninth Ave., Port Arthur.
Adams, Robert M., P. O. Box 878, Groves.
Adkins, Charles F., (Sec'y),
675 Fifth St., Beaumont.
Alexander, Hugh E.,
2372 Calder Ave., Beaumont.
Allamon, Emmett L.,
456 1st Fed. Bldg., Beaumont.
Allison, F. Peel, Hotel Beaumont, Beaumont.
Anderson, Roland B.,
1950 Ninth Ave., Port Arthur.
Andrew, William H., Jr.,
1012 Goodhue Bldg., Beaumont.
Bailey, Percy W., Jr., 675 Fifth St., Beaumont.
Barr, H. Buford,
501 Perlstein Bldg., Beaumont.
Barr, Richard E., (Inac.),
2524 Long Ave., Beaumont.
Bebeau, Eugene R., 3455 Crestwood, Beaumont.
Beck, Edmund J., 2499 Calder, Beaumont.
Bell, Walter L., 1408 W. 6th St., Port Arthur.
Bevil, H. Grady,
514 Amer. Natl. Bk Bldg., Beaumont.
Bevil, Harold H., 2449 Calder Ave., Beaumont.
Bevil, John R., (Hon.),
2625 Laurel Ave., Beaumont.
Bevil, Lamar C., 2625 Laurel Ave., Beaumont.
Beyt, Frank J., 235 Adams Bldg., Port Arthur.
Blackwood, James Q.,
447 1st Fed. Savings Bldg., Beaumont.
Blum, Sigmund L., 573 Pearl St., Beaumont.
Bourgeois, Richard J.,
2301 Procter St., Port Arthur.
Boyle, Frank B., 2248 Procter St., Port Arthur.
Brandau, William H.,
703 Amer. Natl. Bk. Bldg., Beaumont.
Brittain, Robert D., Jr.,
2372 Calder Ave., Beaumont.
Brown, Walter D., (Hon.),
2262 North St., Beaumont.
Browne, Robert S., Adams Bldg., Port Arthur.
Brownrigg, Thos. H.,
1485 Calder Ave., Beaumont.
Bybee, Joe A., 400 Center St., Beaumont.
Byram, Dan H., 2600 Procter St., Port Arthur.
Byrd, Houston F., 1322 Magnolia, Port Neches.
Byrd, Lee Roy, Jr., Box 701, Port Arthur.
Byrd, Peter G., 695½ Forsythe, Beaumont.
Caldwell, Pearson C.,
506 Goodhue Bldg., Beaumont.
Carabelle, R. Wm.,
4300 Lewis Dr., Port Arthur.
Carter, John H.,
460 1st Fed. Savings Bldg., Beaumont.
Carter, Louian C.,
2600 Procter St., Port Arthur.
Catalano, Russell J.,
502 Goodhue Bldg., Beaumont.
Chiasson, John L., (Hon.),
1118 Dearing St., Port Neches.
Chiasson, Mary P.,
261 E. Circuit Dr., Beaumont.
Christie, Alonzo B., Jr.,
Gulf Refinery, Port Arthur.
Chunn, B. D., 1200 Broadway, Beaumont.
Cochran, E. Winston, 675 Fifth St., Beaumont.
Colby, Fred W. C., 2380 Hazel St., Beaumont.
Colletti, Ben M., 521 Atlanta Ave., Port Arthur.
Couch, Ray E., P. O. Box 1059, Port Arthur.
Crager, Jay C., 601 Goodhue Bldg., Beaumont.
Crawford, Geo. F.,
318 Goodhue Bldg., Beaumont.
Crumpler, W. Emmett,
Adams Bldg., Port Arthur.
Cunningham, M. A.,
Jefferson Co. T.B. Hosp., Beaumont.
Curry, Dwight E.,
2600 Procter St., Port Arthur.
Darnell, B. C., 4620 Gladys St., Beaumont.
Douglas, Jake S., 935 Buford St., Beaumont.
Duplan, Don C., Jr.,
4627 Alamosa Dr., Port Arthur.
Duren, Norman,
315 Goodhue Bldg., Beaumont.
Durso, Joseph, 949 7th St., Port Arthur.
Echols, Obie L., 634 Ave. C., Port Neches.
Eisenstadt, Heinz B.,
2301 Procter St., Port Arthur.
Elster, Benjamin B.,
2301 Procter St., Port Arthur.
English, Dudley M., 550 Tenth St., Beaumont.
Erhard, Peter S.,
3010 Blackmon Lane, Beaumont.
Esslinger, Josh J.,
514 Amer. Natl. Bk. Bldg., Beaumont.
Everett, Eva T., 2301 Procter St., Port Arthur.
Fama, Joseph R., 550 Tenth St., Beaumont.
Faulk, M. Edmund, Jr.,
675 Fifth St., Beaumont.
Fears, T. Alvin, Goodhue Bldg., Beaumont.
Ferguson, Edward C.,
Goodhue Bldg., Beaumont.
Fertitta, Julian J., 590 Center St., Beaumont.
Fertitta, Sam J., Jr., 570 Center St., Beaumont.
Fett, Bennie J., Adams Bldg., Port Arthur.
Fortney, Paul N., 550 Tenth St., Beaumont.
Fulbright, Carl W., (Inac.),
4230 Sunken Court, Port Arthur.
Fuqua, Wm. Cruse,
612 Goodhue Bldg., Beaumont.
Furey, Ellen D, 1025 Ave. B, Beaumont.
Fuselier, Julius D., 749 16th St., Port Arthur.
Gardner, John N.,
613 Goodhue Bldg., Beaumont.
Gibson, U. G., 1000 Texas Ave., Port Arthur.
Gill, George G., 370 Tenth St., Beaumont.
Gish, James R., 317 Goodhue Bldg., Beaumont.
Glass, Cecil R., 2462 Calder Ave., Beaumont.
Glass, Walter W., Jr.,
508 Adams Bldg., Port Arthur.
Goldblum, Harvey H.,
3048 Procter St., Port Arthur.
Goodwin, Charles R., 109 12th St., Nederland.
Graber, W. J.,
610 Amer. Natl. Bk. Bldg., Beaumont.
Granata, Samuel V.,
1517 Washington Blvd., Beaumont.
Greenberg, Philip B.,
502 Perlstein Bldg., Beaumont.
Greene, W. Leonard, 670 7th St., Beaumont.
Hager, Dale C., 2040 Park St., Beaumont.
Haig, Martin R., 508 Adams Bldg., Port Arthur.
Hamill, James E.,
2301 Procter St., Port Arthur.
Harlan, H. D., San Jacinto Bldg., Beaumont.
Harper, J. Y., 849 Fifth St., Port Arthur.
Hart, Frank B., 713 Mariposa St., Beaumont.
Hart, John A., 3280 Fannin St., Beaumont.
Hartman, Lee E.,
607 Goodhue Bldg., Beaumont.
Hartman, Sam F., 545 23rd St., Beaumont.
Healey, Gordon, 525 9th Ave., Port Arthur.
Heare, Louis C., Box 312, Port Arthur.
Hearn, J. William, (Int.),
Parkland Mem. Hosp., Dallas.
Hendry, Cullen H., 390 Tenth St., Beaumont.
Hennington, H. M.,
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Hill, Isaac H., 901 Fifth St., Port Arthur.
Hille, Charles D.,
531 Adams Bldg., Port Arthur.
Hines, J. Clarence, Box 746, Nederland.
Hinshaw, Arvil J.,
701 Goodhue Bldg., Beaumont.
Holman, Winston C.,
1931 Ninth Ave., Port Arthur.
Holmes, Glen L., 570 Center St., Beaumont.
Hosen, Harris, 2649 Procter St., Port Arthur.
Hubner, Alan E., 590 Center St., Beaumont.
Hyman, Barnett M.,
1st Fed. Savings Bldg., Beaumont.
Ivers, James B.,
1105 Goodhue Bldg., Beaumont.
Jack, Laurine D.,
511 Goodhue Bldg., Beaumont.
Jacobson, Harry,
523 Perlstein Bldg., Beaumont.
Johnson, Jerry, 519 Goodhue Bldg., Beaumont.
Jones, E. Harrold,
2625 Laurel Ave., Beaumont.
Jones, Edmund D.,
2439 Laurel Ave., Beaumont.
Kalbaugh, Elmore P., Jr.,
2301 Procter St., Port Arthur.
Kaplan, Hyman J.,
206 Goodhue Bldg., Beaumont.
Keith, Frank R., P. O. Box 110, Port Arthur.
Killingsworth, W. Price,
541 9th Ave., Port Arthur.
Knight, John A., (Inac.),
1417 16th Ave., Columbus, Ga.
Knight, Max J., 900 9th Ave., Port Arthur.
Koshkin, Bernard D.,
550 Tenth St., Beaumont.

Kuhlman, Fred Y.,
218 Adams Bldg., Port Arthur.
LaCour, Edward G., 2524 Broadway, Beaumont.
Lancaster, Lifford R.,
921 Goodhue Bldg., Beaumont.
Lanier, Ernest W.,
6272 Jefferson St., Groves.
Larkins, L. Curtis, 755 College St., Beaumont.
Ledbetter, L. H., 550 10th St., Beaumont.
Lewis, Seab J., 2620 Laurel Ave., Beaumont.
Lindsey, Eugene H.,
2372 Calder Ave., Beaumont.
Loewenstein, Joseph M.,
3048 Procter St., Port Arthur.
Lombardo, R. T., 810 19th St., Beaumont.
Lowry, Harvey M.,
319 Goodhue Bldg., Beaumont.
Lyons, Sam B., 801 Goodhue Bldg., Beaumont.
Makins, James, Medical Bldg., Port Arthur.
Mann, David A., (Hon.),
1025 Washington Blvd., Beaumont.
Manning, Wiley M., 2305 Neches, Beaumont.
Marroquin, Luis, 1632 7th Ave., Port Arthur.
Martin, John D., (Hon.),
1897 Rivercrest, Beaumont.
Matlock, Thos. B., Adams Bldg., Port Arthur.
Matthews, Julius B.,
535 W. 13th St., Port Arthur.
McCall, John W., Jr.,
1785 Washington Blvd., Beaumont.
McNemer, Philip H.,
Perlstein Bldg. Annex, Beaumont.
McRee, Edgar C., Medical Bldg., Port Arthur.
McRee, Walter E., Jr.,
3040 Procter St., Port Arthur.
Meeker, Cornelius S.,
3121 Procter St., Port Arthur.
Meyer, Paul R., 3121 Procter St., Port Arthur.
Miller, Kenneth T.,
1115 Goodhue Bldg., Beaumont.
Mitchell, Theo C.,
2449 Calder Ave., Beaumont.
Mixson, Harold J., Goodhue Bldg., Beaumont.
Montagnet, Joseph M., Jr.,
590 Center St., Beaumont.
Moore, Darwin D., (Mil.),
701 Goodhue Bldg., Beaumont.
Moore, Robert E.,
1405 Nederland Ave., Nederland.
Newton, William A.,
2698 McFaddin St., Beaumont.
Norris, Thomas A., (Mil.),
Confederate Mem. Med. Center,
Shreveport, La.
Odell, Joyce W.,
506 Goodhue Bldg., Beaumont.
Orgeron, Eugene B.,
541 Ninth Ave., Port Arthur.
Orrick, Robt. Jack, Jr.,
315 Goodhue Bldg., Beaumont.
Orrill, R. Ray, Medical Bldg., Port Arthur.
Osborne, John A., Jr.,
2462 Calder Ave., Beaumont.
Pace, Bedford F., (Pres.),
555 Tenth St., Beaumont.
Painton, Clifford E.,
900 Ninth Ave., Port Arthur.
Pecora, Tony L.,
610 Goodhue Bldg., Beaumont.
Pentecost, Chas. L.,
503 Perlstein Bldg., Beaumont.
Petit, Paul T., 2627 Laurel Ave., Beaumont.
Petry, James L., 3115 Procter, Port Arthur.
Phillippi, George M.,
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Pierson, Rogers, Box 2908, Beaumont.
Pitre, Roy P., Co. Office Bldg., Port Arthur.
Powell, James E.,
2691 Washington Blvd., Beaumont.
Powell, L. Charles, (Mil.),
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Prudhomme, Eck G., Jr.,
5153 River Oaks Blvd., Fort Worth.
Quick, David W., Jr.,
601 Goodhue Bldg., Beaumont.
Rafes, Earl H., 675 Fifth St., Beaumont.
Raines, James M.,
2002 Procter St., Port Arthur.
Reid, William L., 1195 McFaddin, Beaumont.
Reimers, Arthur F.,
Hotel Beaumont Bldg., Beaumont.
Richardson, Orville J.,
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Richman, Irving M., 3280 Fannin, Beaumont.
Robert, W. Pierre,
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Rollo, William C., Winnie.
Ross, Oliver H., 543 Ninth Ave., Port Arthur.
Rumelt, Allen,
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Sappington, T. B., Jr.,
102 Dryden Place, Port Arthur.
Self, Milton Myrl,
605 Goodhue Bldg., Beaumont.
Serafino, Louis C.,
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Shaddix, Arthur C., 1186 Broadway, Beaumont.
Sheldon, Robert B., 575 19th St., Beaumont.
Shorkey, Richard L., 370 Tenth St., Beaumont.
Simpson, Rufus K.,
2372 Calder Ave., Beaumont.
Sims, Paul M., Jr., 2081 Park St., Beaumont.
Skarke, Edward A.,
2363 Calder Ave., Beaumont.
Sladczyk, George, 3149 Procter St., Port Arthur.
Sloan, John W., 2815 35th St., Port Arthur.
Smith, Denton W., 390 Tenth St., Beaumont.
Smith, Jack L.,
1555 Driskill Dr., Beaumont.
Smith, John T.,
723 Washington Blvd., Beaumont.
Smith, William A.,
211 W. Caldwood Dr., Beaumont.
Solis, G. Robert, 2749 Procter St., Port Arthur.
Sprott, Curtis B., 2390 Cartwright, Beaumont.
Sprott, E. D., Jr., 2390 Cartwright, Beaumont.
Sprott, Maxie C., 2390 Cartwright, Beaumont.
Starr, Harry, 675 Fifth St., Beaumont.
Stephenson, G. Bruce,
370 Tenth St., Beaumont.
Stevens, Robert B.,
1297 Calder Ave., Beaumont.
Stoeltje, Joe, 1170 Simmons St., Beaumont.
Suehs, Max E.,
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Sutton, Fred W., Goodhue Bldg., Beaumont.
Sykes, Walter P., 3280 Fannin, Beaumont.
Tatum, William E., (Hon.),
State Rd., Gatesville.
Tew, Alton H.,
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Thompson, Douglas J.,
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Thompson, James D.,
2600 Procter St., Port Arthur.
Todd, Charles H.,
517 Goodhue Bldg., Beaumont.
Toomin, Leonard A.,
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Torbett, John W., Jr.,
1445 Calder Ave., Beaumont.
Travis, John M., Jr.,
2920 Harrison St., Beaumont.
Tritico, Joseph J., 949 7th St., Port Arthur.
Tyndall, Thomas M.,
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Vaughan, Benjamin H.,
Adams Bldg., Port Arthur.
Walker, Taylor C., 2165 North St., Beaumont.
Wallace, Charles R., 860 Trinity, Beaumont.
Wallace, James C., 860 Trinity, Beaumont.
Wallace, Loring Scott,
1119 Goodhue Bldg., Beaumont.
Wallace, Stuart M.,
1931 Ninth Ave., Port Arthur.
Wallace, William G.,
816 Goodhue Bldg., Beaumont.
Walters, Felix A.,
1133 Boston Ave., Nederland.
Watts, Fenwick L.,
2220 Procter St., Port Arthur.
Weisbach, Philip T.,
560 Center St., Beaumont.
Weiss, Morris, 590 Center St., Beaumont.
Welch, Thomas Lee,
509 W. 10th St., Port Arthur.
Westbrook, Bonnie B., Jr.,
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White, Ben T., 1950 Ninth Ave., Port Arthur.
White, Clarence M.,
618 Amer. Natl. Bk. Bldg., Beaumont.
White, J. Milton, Sr.,
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White, John M., Jr.,
3149 Procter St., Port Arthur.
Wier, Stuart T.,
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Williams, Chas. L., 1776 East Dr., Beaumont.
Williams, Ford G., 415 Center St., Beaumont.
Williams, Lewis M.,
3280 Fannin St., Beaumont.
Williams, Stewart M.,
714 Goodhue Bldg., Beaumont.
Williford, Herman B.,
220 San Jacinto Blvd., Beaumont.
Willoughby, Russell C., Box 535, Groves.
Wilson, Iva G., 811 Main St., Big Spring.
Woodward, John F., Jr.,
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Young, Isaac T., P. O. Box 147, Port Arthur.

LIBERTY-CHAMBERS

Alexander, James H., P. O. Box 606, Cleveland.
Ashby, Joe M., Box 456, Anahuac.
Barnett, William L., (Pres.),
P. O. Box 518, Cleveland.
Bellamy, Richard C., 1815 Cos Ave., Liberty.
Castle, Charles W.,
717 San Jacinto, Liberty.
Clements, Edgar B.,
307 E. Houston St., Cleveland.
Clements, Richard O., (Sec'y),
715 Main, Liberty.
Davidson, Eli, Liberty.
Delaney, Albert L., Liberty.
Fahring, George H., Anahuac.
Fahring, Thomas L., Anahuac.
Gibson, Boyce E., Hull.
Griffin, Frank S., Liberty.
Hume, Boyd Douglas, Jr.,
117 N. College, Cleveland.
Jordan, Byron Lee, (Hon.), Daisetta.
Leggett, Walter, 106 N. Bonham, Cleveland.
Richter, Ernest R., Dayton.
Schulz, Donald P., 608 Travis, Liberty.
Shearer, A. R., Mt. Belvieu.
Wilson, Reginald, Dayton.

NACOGDOCHES

Allen, James I., Nacogdoches.
Allen, Walter B., 1301 Raguet, Nacogdoches.
Beall, J. Frank, 820 N. Mound, Nacogdoches.
Buchele, Matthew J., San Augustine.
Coussons, Charles W., (Sec'y),
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Ferguson, Sarah, 1301 Raguet, Nacogdoches.
Ferwerda, Thomas,
2311 North St., Nacogdoches.
Haley, Curtis R., Baggett Bldg., San Augustine.
McKinney, Edgar P.,
402 E. Hospital St., Nacogdoches.
McLain, Bobby M., Box 337, Garrison.
Nelson, Albert L.,
422 E. Hospital St., Nacogdoches.
Neuville, Carroll F.,
P. O. Box 907, Nacogdoches.
Pennington, Thomas J.,
820 N. Mound, Nacogdoches.
Rogers, Eugene S., (Pres.), Nacogdoches.
Taylor, James G., Jr.,
1301 Raguet, Nacogdoches.
Tucker, F. Henry, Nacogdoches.
Tucker, Stephen B., Nacogdoches.

ORANGE

Allen, Rollie E., 1005 Green Ave., Orange.
Bennett, David, 304 5th St., Orange.
Cloud, James P., 1212 Park Ave., Orange.
Eastman, George L., 1005 Elm, Orange.
Harris, Mattice F., 1014 First St., Orange.
Ingram, Robert A., P. O. Box 479, Orange.
James, Wilson E., 1005 Green St., Orange.
Kent, Earl H., Box 2032, Orange.
Key, Harry H., Box 950, Orange.
McFadden, Irma M., 609 Main St., Orange.
Minkus, Robert F., 5 Circle Q, Orange.
Pearce, H. Wynne, 707 Main St., Orange.
Peters, Leo J., Jr., 601 4th St., Orange.
Pollock, Douglas H., (Sec'y),
610 Park Ave., Orange.
Pretz, Earnest C., 1604 N. Second St., Orange.
Schofield, Elmer C., 1004 Ave. A, Orange.
Seastrunk, Oliver C., 306 10th St., Orange.
Shaddock, Carroll B., 402 2nd St., Orange.
Siddon, William H., P. O. Box 2054, Orange.
Smith, L. C., Box 1368, Vidor.
Stuntz, Billie W., 304 Seventh St., Orange.
Stuntz, Homer C., 304 Seventh St., Orange.
Swickard, George Y., P. O. Box 551, Orange.
Thompson, Louis O.,
121 W. 1st St., Biloxi, Miss.
Walsh, John K., Main and Sixth, Orange.
Watson, Victor D., Box 496, Bridge City.
White, Malcolm E., 203 7th St., Orange.
Williams, Howard C., (Pres.),
1006 Green Ave., Orange.
Wilson, Francis W., P. O. Box 2027, Orange.
Wyllie, James J., 111 Holland Bldg., Orange.

SHELBY-SAN AUGUSTINE-SABINE

Hurst, Thomas L., Center.
Oates, Laried S., 116 Cora St., Center.
Polk, Vernon T., (Sec'y),
108 Church St., Center.
Snider, L. W., Box 246, Joaquin.
Warren, William H., Box 72, Center.
Warren, Wm. Spencer, Center.
Windham, John H., (Hon.), Shelbyville.
Windham, William C., Box 666, Center.

ELEVENTH DISTRICT

Dr. C. E. Willingham, Tyler, Councilor

ANDERSON-HOUSTON-LEON

Bell, Robert H., 109 E. Angelina St., Palestine.
Brown, Adelbert B., Jr., Crockett.
Butler, Charles Wm., Jr., Box 780, Crockett.
Carter, J. Weldon, Palestine.
Cox, Robert G., 804 S. Sycamore St., Palestine.
Darsey, Edward S., Crockett.
Dean, John L., Jr., 407 E. Lamar, Crockett.
Felder, Fred E., Palestine.
Goolsby, Carl B., Med. & Surg. Hosp., Crockett.
Griswold, Culver M., Box 758, Crockett.
Harrington, Oscar B., (Sec'y),
205 E. Neches, Palestine.
Humphries, John T., Palestine.
Hunter, Ripley H., Palestine.
Joyce, Claude D., Jr., Palestine.
Kay, Royal H., Palestine.
King, Marion A., Frankston.
Murray, Carl O., Jr., (Pres.),
208 S. 4th St., Crockett.
Powell, Elisha P., Centerville.
Stokes, Paul B., 210 N. 7th, Crockett.
Wages, A. D., Palestine.
Trice, Leroy, Palestine.
Van Wey, Archie E., Buffalo.
Walkup, Thomas E.,
804 S. Sycamore, Palestine.

CHEROKEE

Adams, Clyde, Box 31, Pineville, La.
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